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DEFENSE HEALTH CARE

Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option

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December 2006

DEFENSE HEALTH CARE

Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option

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Highlights

Highlights of GAO-07-48, a report to congressional committees

Why GAO Did This Study

The Department of Defense (DOD) provides health care through its TRICARE program. Under TRICARE, beneficiaries may obtain care through a managed care option that requires enrollment and the use of civilian provider networks, which are developed and managed by contractors. Beneficiaries who do not enroll may receive care through TRICARE Standard, a fee-for-service option, using nonnetwork civilian providers or through TRICARE Extra, a preferred provider organization option, using network civilian providers. Nonenrolled beneficiaries in some locations have reported difficulties finding civilian providers who will accept them as patients.

The National Defense Authorization Act (NDAA) for fiscal year 2004 directed GAO to provide information on access to care for nonenrolled TRICARE beneficiaries. This report describes (1) how DOD and its contractors evaluate nonenrolled beneficiaries' access to care and the results of these evaluations; (2) impediments to civilian provider acceptance of nonenrolled beneficiaries, and how they are being addressed; and (3) how DOD has implemented the NDAA fiscal year 2004 requirements to take actions to ensure nonenrolled beneficiaries' access to care. To address these objectives, GAO examined DOD's survey results and DOD and contractor documents and interviewed DOD and contractor officials.

www.gao.gov/cgi-bin/getrpt?GAO-07-48.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marcia Crosse at (202) 512-7119 or crossem@gao.gov.

What GAO Found

DOD and contractor officials use various methods to evaluate access to care, and according to these officials, their methods indicate that access is generally sufficient for nonenrolled beneficiaries. For example, in its 2005 survey of civilian providers DOD found that 14 percent of civilian providers surveyed in 20 states were not accepting new patients from any health plan. Of those accepting new patients, about 80 percent would accept nonenrolled TRICARE beneficiaries as new patients. DOD's contractors use various methods to monitor access to care. While these methods were not designed specifically to evaluate access for nonenrolled beneficiaries, they provide information that allows contractors to monitor the availability of both network and nonnetwork civilian providers for this population. According to contractor officials, their measures indicate that nonenrolled beneficiaries' access to care is sufficient overall.

DOD, its contractors, and beneficiary and provider representatives cited various factors as impediments to network and nonnetwork civilian providers' acceptance of nonenrolled TRICARE beneficiaries and ways to address them. These impediments include concerns specific to TRICARE, including reimbursement rates and administrative issues, as well as issues not specific to TRICARE, such as providers without sufficient practice capacity for additional patients. DOD and its contractors have specific ways to address impediments related to reimbursement rates and administrative issues, but issues that are not specific to TRICARE are more difficult to resolve. For example, DOD has authority to increase reimbursement rates for network and nonnetwork civilian providers in areas where access to care has been impaired. Furthermore, other impediments not specific to TRICARE, such as provider practices at capacity and few providers in geographically remote locations, cannot be readily resolved and create access difficulties for all local residents, including TRICARE beneficiaries.

Various DOD offices as well as DOD's contractors are already carrying out the responsibilities outlined by the NDAA for fiscal year 2004—such as educating civilian providers and recommending reimbursement rate adjustments—actions that help ensure nonenrolled beneficiaries' access. However, a senior official was not formally designated to have responsibility for these mandated actions.

DOD commented on the report, stating that GAO's approach was insightful, but disagreeing with GAO's finding that a senior official was not formally designated to be responsible for taking actions to ensure TRICARE beneficiaries' access to care as outlined in the NDAA. DOD said that an existing directive designating a senior official to serve as program manager for TRICARE met this requirement. However, the directive does not specifically designate an official responsible for ensuring access as specified in the NDAA. Nor did DOD take other actions to designate that a senior official have such responsibilities.

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Abbreviations

ART	Assistance Reporting Tool
ASD	Assistant Secretary of Defense
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CPT	current procedural terminology
DOD	Department of Defense
HSA	hospital service area
MCSC	managed care support contractor
MTF	military treatment facility
NDAA	National Defense Authorization Act
OMB	Office of Management and Budget
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TRO	TRICARE regional office

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United States Government Accountability Office
Washington, DC 20548

December 22, 2006

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Duncan L. Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Department of Defense (DOD) offers health care to almost 10 million beneficiaries, including active duty personnel, retirees, and their dependents, through its regionally structured TRICARE program, which is expected to cost about $37 billion in fiscal year 2006. Under TRICARE, health care is available through the military services' system of military hospitals and clinics, referred to as military treatment facilities (MTFs) and through civilian providers. Although DOD and the military services strive to maximize the use of MTFs, TRICARE beneficiaries have received an increasing amount of care through civilian providers. Between fiscal years 2000 and 2005, the percent of inpatient care delivered to TRICARE beneficiaries by civilian providers increased from about 50 percent to an estimated 75 percent. During the same time frame, the percent of outpatient care delivered by civilian providers increased from 39 percent to an estimated 65 percent.[1]

TRICARE has three options for its beneficiaries:[2] Prime, Standard, or Extra. These options vary according to enrollment requirements, the

[1]Fiscal year 2005 data are estimates by the TRICARE Management Activity (TMA) because providers and TRICARE beneficiaries have up to a year to file health care claims.

[2]TRICARE beneficiaries who are eligible for Medicare and enroll in Part B are eligible to receive care under TRICARE for Life. Under this program, TRICARE processes claims after they have been adjudicated by Medicare.

choices beneficiaries have in selecting civilian and MTF providers, and the amount they must contribute towards the cost of their care. Prime, a program in which beneficiaries receive care in a managed care provider network similar to a health maintenance organization, is the only option requiring enrollment and has the lowest copayments. Beneficiaries who enroll in Prime usually obtain health care from the MTF, but they may also obtain care from a network civilian provider when MTF care is not available. Beneficiaries do not need to enroll to receive care under Standard, a fee-for-service option, or Extra, a preferred provider organization option. Under Standard, nonenrolled beneficiaries can obtain health care from civilian providers who do not belong to the TRICARE network but agree to accept TRICARE beneficiaries as patients. Beneficiaries have the highest copayments under Standard. Under Extra, nonenrolled beneficiaries may obtain health care from network civilian providers. Nonenrolled beneficiaries cannot be categorized as belonging to an Extra or Standard group because each time they seek care, they can choose to see either a network or nonnetwork civilian provider, and this choice determines whether they receive coverage under Extra or Standard. Under any option, TRICARE beneficiaries may receive care at an MTF when space is available. Priority for MTF usage is given first to active duty personnel and then to beneficiaries enrolled in Prime.

DOD's TRICARE Management Activity (TMA) uses managed care support contractors (MCSC) to develop networks of civilian providers and perform other customer service functions, such as claims processing, and to ensure that all beneficiaries—including nonenrolled beneficiaries—receive satisfactory service under TRICARE, such as assistance with finding providers. Currently, there is one MCSC for each of TRICARE's three regions—North, South, and West. For each region, TMA has established a TRICARE Regional Office (TRO) and has designated the TRO directors as the health plan managers for their regions with responsibilities such as monitoring provider network quality and adequacy, overseeing the MCSCs, and monitoring customer satisfaction.

Since TRICARE began in 1995, nonenrolled TRICARE beneficiaries in some locations have complained about difficulties finding nonnetwork civilian providers who will accept them as patients. In addition, TRICARE beneficiaries have cited concerns that TMA has focused more attention on the Prime option, which allows TMA to manage beneficiaries' care, and has given less attention to the options available for nonenrolled TRICARE beneficiaries. In response to these concerns, the National Defense Authorization Act (NDAA) for fiscal year 2004 directed DOD to monitor nonenrolled TRICARE beneficiaries' access to care through a survey of

civilian providers.[3] In addition, the NDAA required DOD to designate a senior official to take actions to ensure access to care for nonenrolled TRICARE beneficiaries.

The NDAA for fiscal year 2004 also directed GAO to review the processes, procedures, and analysis used by DOD to determine the adequacy of the number of network and nonnetwork civilian providers and the actions taken to ensure access to care for nonenrolled TRICARE beneficiaries. Specifically, as discussed with the committees of jurisdiction, this report describes (1) how TMA and its MCSCs evaluate nonenrolled TRICARE beneficiaries' access to care and the results of these evaluations; (2) the impediments to civilian provider acceptance of nonenrolled TRICARE beneficiaries, and how they are being addressed; and (3) how DOD has implemented the fiscal year 2004 NDAA requirements to take actions to ensure nonenrolled TRICARE beneficiaries' access to care.

To determine how TMA evaluates nonenrolled TRICARE beneficiaries' access to care, we interviewed and obtained documentation from TMA officials about the civilian provider survey, which included a random, representative sample of civilian providers in selected geographic locations and therefore included both network and nonnetwork civilian providers. We also reviewed information from TMA's annual beneficiary health care survey, which includes information on beneficiaries' access to care. In addition, we met with TRO and MCSC officials for each of the three regions, TMA officials, and representatives from each of the services' Surgeons General to identify and evaluate the tools used for monitoring access to care. To identify the impediments to network and nonnetwork civilian providers' acceptance of nonenrolled TRICARE beneficiaries and how these impediments are being addressed, we obtained information from TMA, TRO, and MCSC officials. We also met with representatives of TRICARE beneficiaries and the American Medical Association to discuss their concerns about impediments to health care access for nonenrolled TRICARE beneficiaries. In addition, we obtained and analyzed data related to TMA's implementation of reimbursement rate increases in specific locations for the purpose of improving access to care. However, we did not evaluate the extent to which the rate increases improved civilian providers' acceptance of TRICARE beneficiaries as patients. To examine how DOD has implemented the fiscal year 2004 NDAA requirements to

[3]See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003) and S. Rep. No. 108-46, at 330 (2003).

take actions to ensure nonenrolled TRICARE beneficiaries' access to care, we obtained information from TMA, TRO, and MCSC officials. Through our review of the relevant documentation and our discussions with TMA, TRO, and MCSC officials, we determined that the data presented in this report were sufficiently reliable for our purposes. We conducted our work from July 2005 through December 2006 in accordance with generally accepted government auditing standards. Appendix I contains more details about our scope and methodology, and appendix II contains more detail about the scope and methodology of DOD's civilian provider survey.

Results in Brief

TMA and its MCSCs use various methods to evaluate access to care, and according to TMA and MCSC officials, the resulting measures indicate that nonenrolled TRICARE beneficiaries' access to care is generally sufficient and that access problems appear to be minimal. Among methods used by TMA to evaluate access to care are its recently implemented civilian provider survey and an annual beneficiary health care survey. The survey of civilian providers, which includes network and nonnetwork providers, is designed to measure access to care by identifying how many civilian providers are willing to accept nonenrolled TRICARE beneficiaries as new patients. The first round of this survey, implemented in 2005, focused on 20 states and found that 14 percent of civilian providers were not accepting new patients from any government or commercial health plan. Of those accepting new patients, about 80 percent would accept nonenrolled TRICARE beneficiaries as new patients. In addition, the results of each of TMA's annual beneficiary health care surveys for 2003 through 2005 show that nonenrolled TRICARE beneficiaries' satisfaction with access to care was similar to satisfaction reported by participants in commercial health plans. TMA and the TROs also receive anecdotal information through beneficiary feedback, and, according to these officials, complaints about access to care are infrequent. Each of the MCSCs also has its own methods of monitoring access to care, including analyzing provider and beneficiary locations as part of their responsibility for ensuring sufficient network capacity for all TRICARE beneficiaries residing in locations with civilian provider networks. While the MCSCs' methods were not designed specifically to evaluate access for nonenrolled TRICARE beneficiaries, they do provide helpful information that allows the MCSCs to monitor the availability of both network and nonnetwork civilian providers for this population. According to MCSC officials, their measures indicate that nonenrolled TRICARE beneficiaries' access to care is sufficient overall.

TMA, MCSCs, and beneficiary and provider representatives cited various factors as impediments to network and nonnetwork civilian providers' acceptance of nonenrolled TRICARE beneficiaries and different ways to address them. These impediments include concerns that are specific to the TRICARE program, including reimbursement rates and administrative issues, as well as issues that are not specific to TRICARE, such as providers not having sufficient capacity in their practices for additional patients and provider shortages in geographically remote areas. TMA and the MCSCs have specific ways to respond to impediments related to TRICARE reimbursement rates and administrative issues, while the others are more difficult to address. For example, TMA has the authority to increase reimbursement rates for network and nonnetwork civilian providers in locations where TMA determines that access to care is impaired. Using this authority, TMA has increased reimbursement rates for specific services for network and nonnetwork civilian providers in 15 locations, including two waivers covering the state of Alaska. To respond to network and nonnetwork civilian providers' concerns about administrative issues, such as problems with claims processing, MCSCs are working to educate providers on TRICARE requirements. However, while MCSCs and TMA believe that efforts to increase reimbursement rates and assist providers with administrative issues have improved access to care, the actual extent to which these efforts have improved access is unclear. Nonetheless, other impediments that are not specific to TRICARE are more difficult for TMA and MCSCs to resolve. For example, some network and nonnetwork civilian providers do not accept nonenrolled TRICARE beneficiaries as new patients because their practices are already at capacity. In addition, there are few practicing civilian providers, either network or nonnetwork, in some geographically remote areas, impairing access for all local residents, including TRICARE beneficiaries. Recently TMA has adopted two bonus payment systems similar to those used by Medicare for locations with provider shortages.

Various TMA offices, including the TROs, and the MCSCs are carrying out the responsibilities outlined by the NDAA for fiscal year 2004—such as educating civilian providers and recommending reimbursement rate adjustments—actions that help ensure nonenrolled beneficiaries' access to care. For example, in some locations, the TROs have recommended adjustments to reimbursement rates when access to care was impaired. Other activities, such as educating nonnetwork civilian providers, are shared by the TROs, other TMA offices, and the MCSCs. However, a senior official was not formally designated to have responsibility for these actions as required in this mandate.

DOD said our approach used to address issues in this report was thoughtful and insightful, but DOD disagreed with our finding that a senior official was not formally designated to take actions to ensure adequate access to care for nonenrolled TRICARE beneficiaries, including ensuring adequate participation by nonnetwork providers, as outlined by the NDAA for fiscal year 2004. DOD stated that the agency has an existing directive that designates a senior official to serve as program manager for TRICARE, which meets the NDAA mandate for nonenrolled beneficiaries. However, we do not agree that DOD has adequately addressed the mandate. First, during our audit work we found that no specific actions had been taken to designate a senior official. Second, while the responsibilities of the TMA Director and the TROs under the directive generally encompass provision of care to nonenrolled beneficiaries, the directive does not task any one official with identifying the specific actions necessary to ensure adequate provider participation in each market area, as the law required.

Background

In fiscal year 2005, almost 10 million beneficiaries were eligible to receive health care under TRICARE, DOD's regionally structured health care program. Under TRICARE, beneficiaries have choices among three different benefit options and may obtain care from either MTFs or civilian providers. The NDAA for fiscal year 2004 directed DOD to conduct a survey to monitor access to care for beneficiaries who chose not to use TRICARE's managed care option and to appoint a senior official to take actions to ensure that these beneficiaries have adequate access to care.

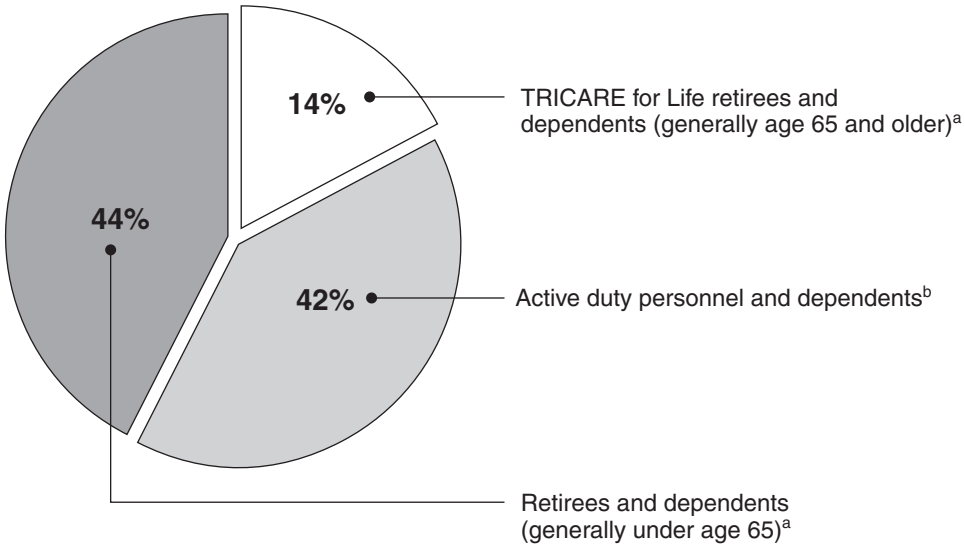
Composition of TRICARE's Beneficiary Population

TRICARE beneficiaries fall into various categories, including active duty personnel and their dependents and retirees and their dependents. Retirees and certain dependents and survivors who are entitled to Medicare Part A and enrolled in Part B, and who are generally age 65 and older,[4] are eligible to obtain care under a separate program called

[4]TRICARE beneficiaries under 65 years of age who are eligible for Medicare Part A on the basis of disability or end stage renal disease are eligible for TRICARE for Life if they enroll in Medicare Part B.

TRICARE for Life (TFL).[5] As shown in figure 1, active duty personnel and their dependents represent 42 percent of the beneficiary population. Retirees and their dependents who are not entitled to Medicare (generally under age 65) comprised 44 percent of the TRICARE beneficiary population while retirees and dependents over 65 represented 14 percent of the beneficiary population.

Figure 1: TRICARE Beneficiaries in Fiscal Year 2005



Source: GAO analysis of DOD data.

[a]TRICARE beneficiaries under 65 years of age who are eligible for Medicare Part A on the basis of disability or end stage renal disease are eligible for TRICARE for Life if they enroll in Medicare Part B.

[b]National Guard and reservists who have been activated are included as active duty personnel and their family members are included as dependents.

[5]TRICARE for Life is a program for Medicare-eligible beneficiaries enrolled in Medicare Part B, which covers charges from licensed practitioners, as well as clinical laboratory and diagnostic services, surgical supplies and durable medical equipment, and ambulance services. TRICARE for Life pays expenses remaining after Medicare has paid its share of claims and also pays for certain skilled nursing and inpatient hospitalization services that Medicare does not cover.

Network and Nonnetwork Civilian Providers Under TRICARE

TRICARE beneficiaries can choose to obtain health care through MTFs or through civilian providers, which includes providers who belong to the TRICARE provider network as well as nonnetwork providers who agree to accept TRICARE beneficiaries as patients. Individual civilian providers must be licensed by their state, accredited by a national organization, if one exists, and meet other standards of the medical community to be authorized to provide care under TRICARE. Individual TRICARE-authorized civilian providers can include attending physicians, certified nurse-practitioners, clinical nurse specialists, dentists, clinical psychologists, physician assistants, podiatrists, and optometrists, among others. There are two types of authorized civilian providers—network and nonnetwork providers. Network civilian providers are TRICARE-authorized providers who enter a contractual agreement with the regional MCSC to provide health care to TRICARE beneficiaries. By law, TRICARE maximum allowable reimbursement rates must generally mirror Medicare rates, but network providers may agree to accept lower reimbursements as a condition of network membership. In some cases, they agree to accept negotiated reimbursement rates, which are usually discounts off of the TRICARE reimbursement rates, as payment in full for medical care or services. Network civilian providers are reimbursed at their negotiated rate regardless of whether they are providing care to enrolled TRICARE beneficiaries under the Prime option or nonenrolled TRICARE beneficiaries under the Extra option. Network civilian providers file claim forms for TRICARE beneficiaries and follow other contractually required processes, such as those for obtaining referrals. However, network civilian providers are not obligated to accept all TRICARE beneficiaries seeking care. For example, a network civilian provider may decline to accept TRICARE beneficiaries as patients because the provider's practice does not have sufficient capacity or for other reasons.[6]

Nonnetwork civilian providers are TRICARE-authorized providers who do not have a contractual agreement with an MCSC to provide care to TRICARE beneficiaries.[7] Nonnetwork civilian providers may accept TRICARE beneficiaries as patients on a case-by-case basis. These providers may choose to accept the TRICARE reimbursement rate as

[6]For example, network providers may determine that only a set amount of their practice—such as 10 or 20 percent—will be allocated to TRICARE patients. When this percentage is met, providers may decline to accept any new TRICARE patients.

[7]TRICARE beneficiaries who choose to receive medical care from providers who are not TRICARE-authorized may be responsible for all billed charges.

payment in full for their services on a case-by-case basis. This practice is referred to as "participating" or accepting assignment on a claim. Nonnetwork civilian providers also have the option of charging up to 15 percent more than the TRICARE reimbursement rate for their services on a case-by-case basis—a practice referred to as "non-participating." However, when a nonnetwork civilian provider bills more than the TRICARE reimbursement rate, TRICARE beneficiaries are responsible for paying the extra amount billed in addition to their required copayments. TROs and MCSCs told us that this authority is infrequently used, in part, because when providers bill the additional 15 percent, they usually collect their total reimbursement from the TRICARE beneficiaries, who may not always pay promptly.[8] When nonnetwork civilian providers "participate" on a claim and agree to accept the TRICARE reimbursement amount as payment in full, the MCSCs usually pay them directly, ensuring timely payment of the claim.

TRICARE's Benefit Options

TRICARE provides its benefits through three main options for its non-Medicare eligible beneficiary population that vary according to TRICARE beneficiary enrollment requirements, the choices TRICARE beneficiaries have in selecting civilian and MTF providers, and the amount TRICARE beneficiaries must contribute towards the cost of their care. However, while there are three main options, there are only two types of TRICARE beneficiaries—enrolled and nonenrolled—and two types of civilian providers—network and nonnetwork. (See table 1.) All beneficiaries may also obtain care at MTFs although priority is given to active duty beneficiaries and Prime enrollees.

[8]Between fiscal years 2001 and 2005 the percent of nonnetwork civilian providers who billed TRICARE beneficiaries an additional 15 percent over the TRICARE reimbursement rate on some of their claims decreased from 10 percent to 6.3 percent. Similarly, the percent of nonnetwork civilian providers who billed an additional 15 percent over the TRICARE reimbursement rate on all of their claims decreased from 7.4 percent in fiscal year 2001 to 4.4 percent in fiscal year 2005.

Table 1: Summary of the Three Main TRICARE Options

TRICARE option	Type of option	Enrollment required	Enrollment fee	Civilian provider status[a]	Deductible	Beneficiary copayment (outpatient care)[b]
Prime	Managed care	Yes	Yes[c]	Network	None	$0–$12[d]
Standard	Fee-for-service	No	No	Nonnetwork	$50-$150 per individual; $100-$300 per family[f]	20–25% of the TRICARE reimbursement rate[e]
Extra	Preferred provider organization	No	No	Network	$50-$150 per individual; $100-$300 per family[f]	15–20% of the TRICARE reimbursement rate

Source: GAO analysis of DOD data.

[a]Beneficiaries may also use MTF providers. Priority for MTF usage is given to active duty personnel and beneficiaries enrolled in Prime.

[b]The lower range of copayments apply to active duty dependents while higher copayments apply to retirees and their dependents. There is no charge for outpatient care received at MTFs.

[c]There is no enrollment fee for active duty servicemembers and their dependents. However, retirees and their dependents under 65 years must pay an annual enrollment fee of $230 per individual or $460 per family.

[d]Inpatient care and other types of service require different levels of copayment for retirees. Active duty family members who enroll in Prime never incur a copayment.

[e]On a case-by-case basis, nonnetwork civilian providers may charge up to 15 percent more than the TRICARE reimbursement rate. In these instances, the TRICARE beneficiaries are also responsible for this amount in addition to copayments.

[f]Dependents of lower-ranked enlisted personnel pay lower deductible amounts. Dependents of higher-ranked military personnel, as well as retirees and their dependents, pay the higher deductible amounts.

The three main options with their corresponding enrollment requirements and provider categories are as follows:

- **TRICARE Prime**: This managed care option is the only TRICARE option requiring enrollment. Active duty servicemembers are required to enroll in this option while other TRICARE beneficiaries may choose to enroll.[9] Prime enrollees receive most of their care from providers at MTFs, augmented by network civilian providers who have agreed to meet specific access standards for appointment wait times among other

[9]To use the TRICARE Prime option, eligible TRICARE beneficiaries must reside in locations where TRICARE Prime is offered.

requirements.[10] Prime enrollees have a primary care manager who either provides care or authorizes referrals to specialists. Beneficiaries can be assigned to a primary care manager at the MTF or, if the MTF is at capacity or no MTF is available, Prime enrollees may select a civilian primary care manager. Prime offers lower out-of-pocket costs than the other TRICARE options. Active duty personnel and their dependents do not pay enrollment fees, annual deductibles, or copayments for care obtained from network civilian providers. Retirees and their dependents who are not entitled to Medicare pay an annual enrollment fee and small copayments for care obtained from network civilian providers.

- **TRICARE Standard**: TRICARE beneficiaries who choose not to enroll in Prime may obtain health care using this fee-for-service option, which is designed to provide maximum flexibility in selecting providers. Under Standard, nonenrolled TRICARE beneficiaries may obtain care from TRICARE-authorized nonnetwork civilian providers of their choice. TRICARE beneficiaries using this option do not need a referral for most specialty care. Under Standard, all TRICARE beneficiaries must pay an annual deductible and copayments, which vary among active duty dependents and retirees and their dependents, and there is no annual enrollment fee.[11] In addition, nonnetwork providers are not required to meet access standards, such as those for appointment wait times.

- **TRICARE Extra**: Similar to a preferred-provider organization, nonenrolled TRICARE beneficiaries may also obtain health care from a TRICARE network civilian provider for lower copayments than they would have under the Standard option—about 5 percent less. TRICARE beneficiaries choosing to use Extra must pay towards the same annual deductible as Standard and are responsible for copayments. Similar to Standard, there is no annual enrollment fee. Additionally, network civilian providers caring for nonenrolled TRICARE beneficiaries must adhere to the same access standards for appointment wait times that they use for enrolled TRICARE beneficiaries under Prime.

[10]Prime enrollees may also receive care from nonnetwork providers; however, such care is subject to deductibles and copayments of 50 percent of the TRICARE reimbursement rate unless the enrollee has a referral for the care from the Primary Care Manager.

[11]The annual deductible also varies from $50 to $150 per person or from $100 to $300 per family. Dependents of lower-ranked active duty enlisted personnel pay the lower deductible amounts. Dependents of high-ranked personnel and retirees and their dependents pay the higher deductible amounts.

Among TRICARE beneficiaries who were not Medicare eligible in fiscal year 2005, about 5.5 million or 65 percent of TRICARE's beneficiaries were enrolled in Prime and thereby declared their intent to use their TRICARE benefit. In contrast, TMA does not know whether nonenrolled beneficiaries intend to use their TRICARE benefit. In fiscal year 2005, claims data showed that about 1.2 million or 14 percent of nonenrolled TRICARE beneficiaries obtained care with 66 percent of this care being delivered through the Standard option and 34 percent delivered through the Extra option. The remaining 1.8 million or 21 percent of nonenrolled beneficiaries were eligible for TRICARE benefits but did not use them during this time period.[12] At any time, this population of eligible nonusers could elect to use Standard or Extra, and DOD would reimburse claims submitted for their health care after annual deductibles are met.

TRICARE Contracts and Regional Structure

TMA uses three MCSCs to provide civilian health care under the TRICARE program. Each MCSC is responsible for the delivery of care to TRICARE beneficiaries in one of three geographic regions—North, South, and West. The MCSCs are contractually required to establish and maintain networks of civilian providers in designated locations within these regions that are referred to as Prime Service Areas. (See fig. 2 for the location of Prime Service Areas in each of the three TRICARE regions.) Prime Service Areas include all MTF enrollment areas,[13] Base Realignment and Closure sites,[14] and additional areas where either TMA or the MCSC deems networks to be cost effective. As a result, each region may contain multiple Prime Service Areas. In these areas, civilian provider networks are required to be large enough to provide access for all TRICARE beneficiaries regardless of enrollment status or Medicare-eligibility. TMA contractually requires that MCSCs' civilian provider networks meet specific access standards, such as travel times or wait times, for both primary and specialty care. For example, TRICARE beneficiaries seeking primary care should not have to drive more than 30 minutes to get to their appointment locations. In

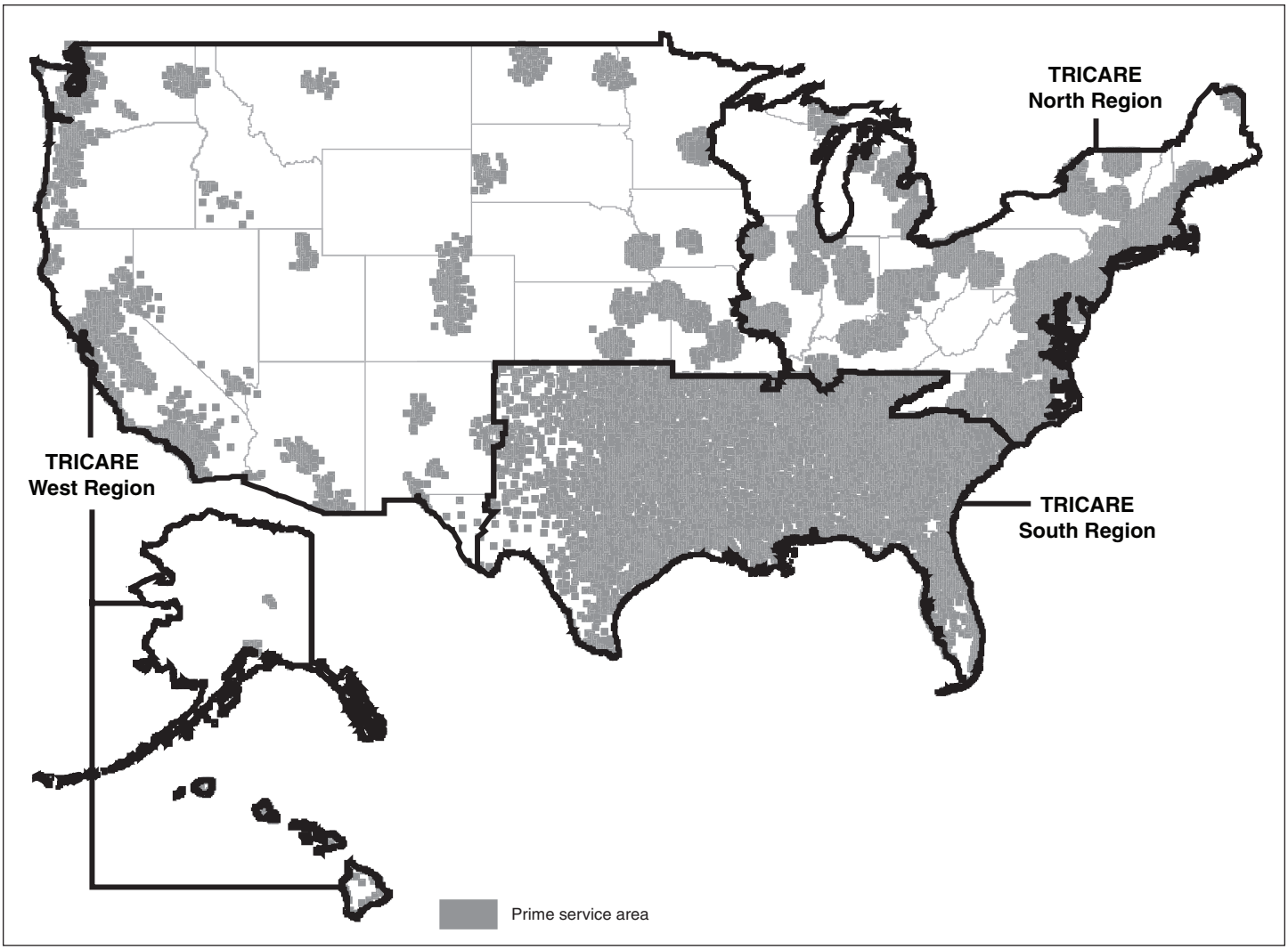
[12]About 1.3 million additional beneficiaries were eligible for TRICARE for Life in fiscal year 2005.

[13]MTF enrollment areas are geographic areas determined by the ASD for Health Affairs that are defined by five-digit zip codes, usually within an approximate 40-mile radius of MTFs with inpatient care. In areas encompassing MTFs, the civilian provider networks are expected to complement the clinical services provided in MTFs.

[14]Base Realignment and Closure sites are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

addition to contractual requirements, the MCSCs can add additional access standards that they strive to meet.

Figure 2: Location of Prime Service Areas in Each TRICARE Region



Source: GAO analysis of DOD data.

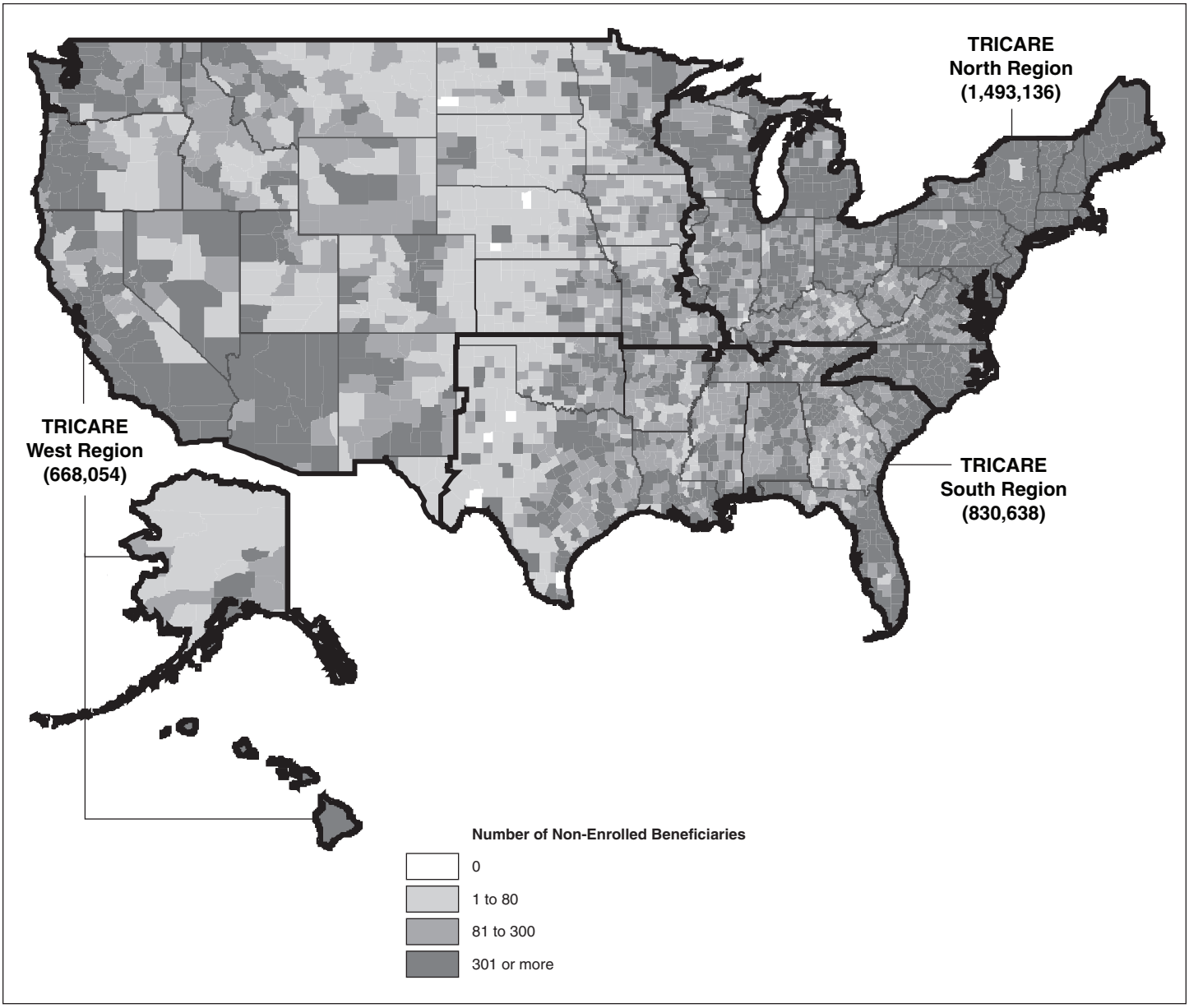
Note: Shaded areas represent counties in which there was a TRICARE network of civilian providers available to serve both enrolled and nonenrolled beneficiaries.

MCSCs are also responsible for performing other customer service functions, such as processing claims and helping TRICARE beneficiaries locate providers. They also are required to operate TRICARE Service Centers, which are frequently located within MTFs, to provide TRICARE beneficiaries with information on the different TRICARE options, information on benefit coverage, assistance with finding network and nonnetwork civilian providers, determining eligibility status, and other activities. MCSCs provide customer service to any TRICARE beneficiary who requests assistance, regardless of their enrollment status.

In each of the three regions, TMA uses a TRO to manage health care delivery. TRO directors are considered the health plan managers for the regions and are responsible for overseeing the MCSCs, including monitoring network quality and adequacy, monitoring customer satisfaction outcomes, and coordinating appointment and referral management policies. TRO directors and staff also provide customer service to all TRICARE beneficiaries who request assistance regardless of their enrollment status.

Although they vary in the size of the geographic area covered, each TRICARE region has approximately the same number of TRICARE beneficiaries. However, the number of nonenrolled TRICARE beneficiaries varies by region as does their access to network providers under the Extra option depending on their proximity to a Prime Service Area. (See fig. 3 for the number and distribution of nonenrolled beneficiaries by region.)

Figure 3: All Nonenrolled TRICARE Beneficiaries by Region



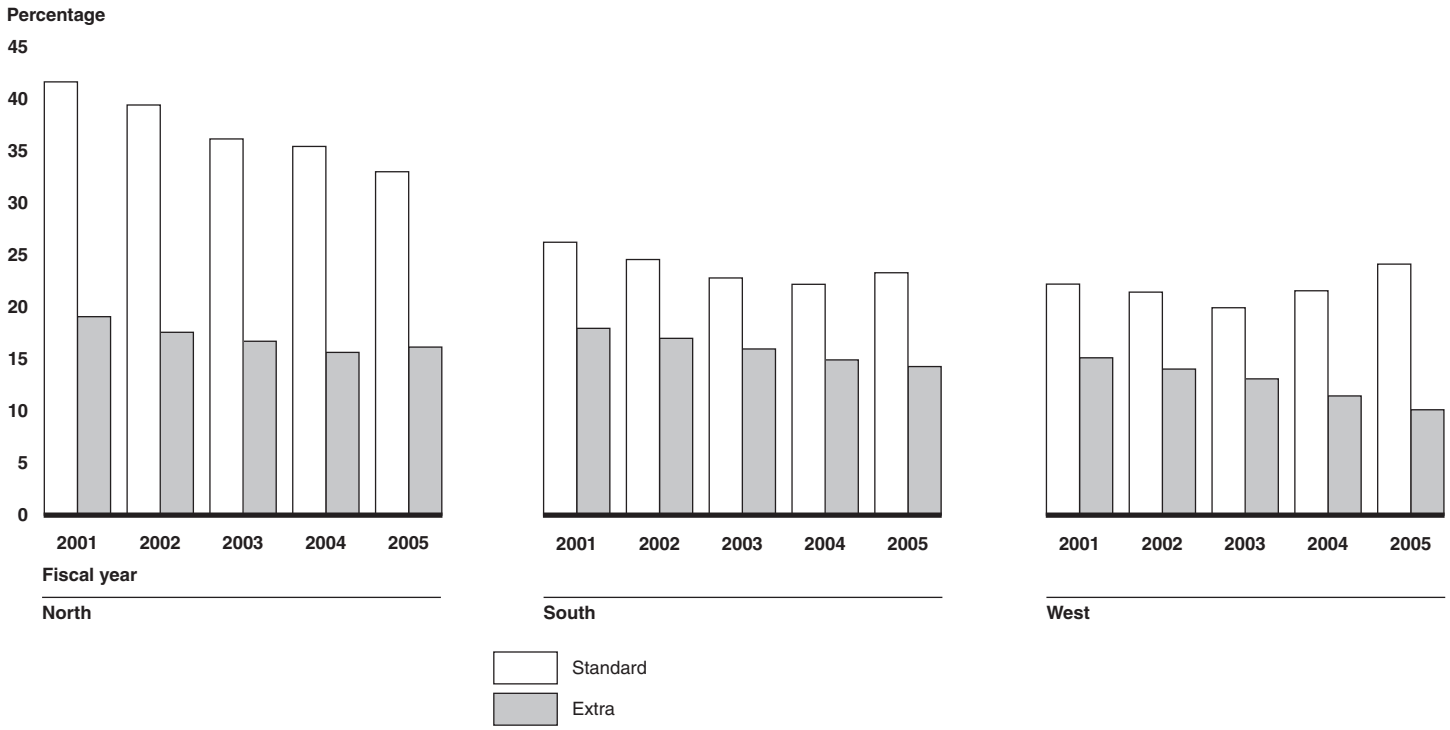
Source: GAO analysis of DOD data.

Note: Shaded areas represent counties where nonenrolled beneficiaries resided.

Throughout the three regions, about 16 percent of nonenrolled TRICARE beneficiaries reside outside of Prime Service Areas. In the North region, 23 percent of nonenrolled TRICARE beneficiaries live outside of Prime Service Areas, and in the West Region, 21 percent of nonenrolled TRICARE beneficiaries live outside of Prime Service areas. Because the South Region has extensive Prime Service Areas, no TRICARE beneficiaries live in locations without a civilian provider network.

Although most nonenrolled TRICARE beneficiaries nationwide live in a Prime Service Area, making Extra a readily available option, nonenrolled TRICARE beneficiaries have used Standard more frequently than Extra for each fiscal year from 2001 through 2005. (See fig. 4.)

Figure 4: Percent of Claims Paid for TRICARE Standard and Extra for Each TRICARE Region for Fiscal Years 2001-2005



Source: GAO analysis of TMA data.

Note: In 2004, TMA consolidated its 11 TRICARE regions into 3 TRICARE regions. TMA officials reallocated the data from the 11 regions to correspond to the current regional structure.

Requirements in the NDAA for Fiscal Year 2004 Related to Nonenrolled TRICARE Beneficiaries

The NDAA for fiscal year 2004 directed DOD to monitor nonenrolled TRICARE beneficiaries' access to care under the TRICARE Standard option and to designate a senior official to take the actions necessary to ensure access to care for nonenrolled TRICARE beneficiaries.[15] Specifically, the NDAA required surveys to be done in 20 market areas[16] each fiscal year until all markets were surveyed to determine how many civilian providers[17] were accepting nonenrolled TRICARE beneficiaries as new patients. Although the law focused on Standard, TMA officials told us that since nonenrolled TRICARE beneficiaries can receive care through both the Standard and Extra options, they designed the survey to monitor access to care from both network and nonnetwork providers.

When developing the survey's methodology, TMA defined market areas as individual states and determined that all states could be surveyed within a 3-year period. TMA implemented its survey in fiscal year 2005 for the first 20 states.[18] The survey collected data from the billing and insurance specialists of selected civilian providers, both network and nonnetwork, to determine how many were accepting nonenrolled TRICARE beneficiaries as new patients and to identify the reasons providers cite for not accepting these TRICARE beneficiaries. About 17 percent of the providers in the sample belonged to a TRICARE network while the remaining 83 percent of providers in the sample were nonnetwork providers. Because about 14 percent of all civilian providers belong to the TRICARE network, TMA's sample of civilian providers is fairly representative of the network and nonnetwork civilian provider population serving all TRICARE beneficiaries, including nonenrolled beneficiaries who can use the Standard and Extra options. TMA's four-question survey focused on a given provider's awareness of TRICARE, whether the provider was accepting nonenrolled beneficiaries as new patients, and if not, the

[15]See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003) and S. Rep. No. 108-46, at 330 (2003).

[16]Neither the NDAA nor any congressional reports accompanying the legislation provided a definition for 'market areas.'

[17]The NDAA did not specify network or nonnetwork providers for the survey, but both types of providers can accept nonenrolled TRICARE beneficiaries as patients. Network providers see nonenrolled TRICARE beneficiaries under TRICARE's Extra option.

[18]TMA obtained clearance to distribute its Survey of Continued Viability of TRICARE Standard (the civilian provider survey) from the Office of Management and Budget on May 16, 2005. This clearance is required by the Paperwork Reduction Act. See 44 U.S.C. §§ 3507 and 3508.

reasons why they were not. (See app. II for a detailed discussion of the methodology used for this survey and app. III for the complete survey instrument.)

The NDAA for fiscal year 2004 also required DOD to designate a senior official to take actions necessary for achieving and maintaining the participation of nonnetwork civilian providers in a number adequate to ensure care for nonenrolled TRICARE beneficiaries in each market area. According to this legislation, the senior official would have the following responsibilities:

- educating nonnetwork civilian providers about TRICARE,
- encouraging nonnetwork civilian providers to accept nonenrolled TRICARE beneficiaries as patients,
- ensuring that nonenrolled TRICARE beneficiaries have the information necessary to locate nonnetwork civilian providers readily, and
- recommending adjustments in reimbursement rates that the official considers necessary to ensure adequate availability of nonnetwork civilian providers for nonenrolled TRICARE beneficiaries.

TMA and Its MCSCs Use Various Methods to Evaluate Access to Care That Indicate Sufficient Access for Nonenrolled TRICARE Beneficiaries

TMA and its MCSCs use various methods for evaluating access to care, and according to TMA and MCSC officials, the resulting measures indicate that access to care is generally sufficient for nonenrolled TRICARE beneficiaries. TMA is administering the civilian provider survey required by the NDAA for fiscal year 2004, which is designed to obtain information on network and nonnetwork civilian providers' willingness to accept nonenrolled TRICARE beneficiaries as new patients. TMA also obtains information about access to care through its annual health care survey of all TRICARE beneficiaries and through the anecdotal beneficiary feedback they receive from the TROs, which monitor access in their respective regions. MCSCs also use a variety of approaches to evaluate access to care, including inquiries from beneficiaries, analyses of claims data, and monitoring of the capacity of civilian provider networks.

TMA Uses Various Methods for Evaluating Access to Care

TMA uses multiple methods of evaluating access to care for its nonenrolled TRICARE beneficiaries, including the recently implemented survey of civilian providers and its annual health care survey of TRICARE beneficiaries. In addition, TMA monitors centrally received beneficiary

complaints and inquiries, and each TRO monitors access to care in its respective region.

TMA's Survey of Civilian Providers

In fiscal year 2005, TMA completed the first phase of its mandated survey of civilian health care providers.[19] (See app. II for discussion of technical aspects of this survey's methodology.) Although the survey was designed to determine the extent to which providers were willing to accept nonenrolled TRICARE beneficiaries as new patients, it is premature to interpret the results because this is the first of three rounds of the survey, and TMA does not have an established benchmark for determining the number of civilian providers that are needed for nonenrolled beneficiaries. During this initial round, TMA randomly selected a representative sample of over 40,000 providers in 20 states. TMA found that the majority of the providers surveyed were accepting new patients, including nonenrolled TRICARE beneficiaries.[20] Specifically, only 14 percent of providers reported that they were not accepting new patients, including TRICARE patients, privately insured patients, or patients who were paying for their own care. Of the remaining 86 percent accepting new patients, the percent that would accept nonenrolled TRICARE beneficiaries as new patients averaged 80 percent for all 20 states.[21] (See table 2 for overall results by state.) An additional comparison of the acceptance rate for two categories of providers—primary care providers[22] and specialists[23]—in each of these 20 states revealed very little difference between the two categories.[24] Of those accepting new patients, 78 percent of primary care providers and

[19]In accordance with the law, TMA plans to conduct a survey of civilian health care providers using a 3-year phased approach, surveying 20 states in each year for 2 years, and 10 states plus the District of Columbia during the final year.

[20]In fiscal year 2004 TMA piloted this survey in 20 cities where TRICARE beneficiary advocacy groups anecdotally identified problems with access to care for nonenrolled TRICARE beneficiaries.

[21]This ranged from a low of 68 percent in New York to a high of 93 percent in South Dakota.

[22]The primary care provider category consists of providers whose specialties include family or general practice, internal medicine, obstetrics and gynecology, or pediatrics.

[23]The specialist category consists of all other medical specialties not captured in the primary care category.

[24]TMA did not subdivide primary care and specialist providers into network and nonnetwork categories.

81 percent of specialists would accept nonenrolled TRICARE beneficiaries as new patients.[25]

Table 2: TMA's 2005 Civilian Provider Survey Results Showing Percent of Surveyed Providers Accepting Nonenrolled TRICARE Beneficiaries (of Those Accepting New Patients) by State

Surveyed states	Percent of surveyed providers accepting nonenrolled TRICARE beneficiaries (of those accepting new patients)
South Dakota	93
Maine	92
Idaho	91
Kansas	90
Mississippi	89
Nebraska	89
Wyoming	88
Alaska	87
Wisconsin	87
Massachusetts	87
New Mexico	86
Indiana	84
South Carolina	84
Illinois	83
California	81
Washington	79
Delaware	78
Texas	76
New Jersey	70
New York	68
Total	**80**

Source: GAO analysis of DOD data.

[25]Indiana is the only state, among those surveyed, with a statistically significant difference in acceptance rates between primary care and specialist providers. However, both primary care and specialist acceptance rates in Indiana are relatively high, with 89 percent of specialists and 78 percent of primary care providers accepting new nonenrolled TRICARE beneficiaries.

In addition to the statewide sample, TMA also sampled civilian providers in several smaller geographic locations, defined as hospital service areas (HSA),[26] in order to respond to concerns about access to care that were specific to certain locations. TMA selected 29 HSAs—12 that were randomly selected from within the 20 states evaluated for fiscal year 2005 and 17 based on beneficiary concerns about specific locations.[27] As in the 20-state survey, TMA found that most providers in the selected HSAs were accepting new patients, including nonenrolled TRICARE beneficiaries. Specifically, only 13 percent of surveyed providers reported that they were not accepting new patients. Of the remaining 87 percent accepting new patients, 81 percent were accepting nonenrolled TRICARE beneficiaries as new patients. (See table 3.) An additional comparison of the acceptance rates for primary care providers and specialists who were accepting new patients revealed that 75 percent of the surveyed primary care providers and 85 percent of the surveyed specialists would accept nonenrolled TRICARE beneficiaries as new patients.[28] A further comparison of providers accepting nonenrolled TRICARE beneficiaries as new patients between the HSAs selected based on TRICARE beneficiaries' concerns and the HSAs randomly selected from the 20 surveyed states showed minimal difference in acceptance rates—80 percent and 83 percent, respectively.

[26]HSAs are collections of zip codes organized into over 3,000 geographic regions in which Medicare beneficiaries seek the majority of their care from one hospital or a collection of hospitals. HSAs have nonoverlapping borders and contain all U.S. zip codes without gaps in coverage.

[27]Four of the HSAs selected by TRICARE beneficiaries—two in Florida and two in Michigan—were located outside of the selected states.

[28]In one community, Arlington, Texas, the survey found a sizeable difference in the rate of acceptance between primary care providers (47 percent) and specialists (73 percent).

Table 3: TMA's 2005 Civilian Provider Survey Results Showing Percent of Surveyed Providers Accepting Nonenrolled TRICARE Beneficiaries (of Those Accepting New Patients) by Hospital Service Area

Hospital Service Areas[a]	Percent of surveyed providers accepting nonenrolled TRICARE beneficiaries (of those accepting new patients)
Peoria, Illinois[b]	96
Fort Wayne, Indiana[b]	94
Battle Creek, Michigan[b]	93
Watertown, New York	92
Santa Fe, New Mexico[b]	90
Eau Claire, Wisconsin[b]	90
Belleville, Illinois	87
Waukegan, Illinois	87
Evansville, Indiana	89
Charleston, South Carolina[b]	87
Lafayette, Indiana[b]	87
Syracuse, New York	86
Corpus Christi, Texas[b]	84
Killeen, Texas	84
Spokane, Washington	84
San Diego, California	83
Tallahassee, Florida[b]	83
Kalamazoo, Michigan[b]	80
San Antonio, Texas	80
Boca Raton, Florida[b]	79
Indianapolis, Indiana	79
Columbia, South Carolina	79
Sacramento, California[b]	77
Olympia, Washington	72
Houston, Texas[b]	68
Monterey, California[b]	67
Arlington, Texas[b]	62
Brooklyn, New York[b]	60
Seattle, Washington[b]	60
Total	**81**

Source: GAO analysis of DOD data.

[a]Hospital Service Areas are collections of zip codes organized into geographic regions in which Medicare TRICARE beneficiaries seek the majority of their care from one hospital or a collection of hospitals. Hospital Service Areas have nonoverlapping borders and contain all U.S. zip codes without gaps in coverage.

[b]Locations requested by TRICARE beneficiary groups and TRICARE Regional Offices for assessment of access to care. These locations were not randomly selected.

In both the states and HSAs, civilian providers who indicated that they were not accepting nonenrolled TRICARE beneficiaries as new patients were asked to identify why they made this decision in their own words, and were permitted to provide as many reasons as they wanted. More than half of both network and nonnetwork respondents cited not having a provider available or reimbursement issues as reasons. For providers citing nonavailability as a reason, many explained that they were either in the process of retiring or were too busy to accept any new patients at this time. Providers citing reimbursement issues most often stated an opinion that TRICARE's reimbursement rates were low and that claims payment was slow. (See app. IV for TMA's summary of the aggregate results by category.)

Although there is no benchmark with which to compare the results of the initial civilian provider survey effort, TMA officials stated that their analysis of the 2005 survey results did not indicate widespread problems with nonenrolled TRICARE beneficiaries' access to care. Nonetheless, TRO officials used the survey results to identify specific cities in their regions where civilian providers' acceptance of nonenrolled TRICARE beneficiaries and knowledge about TRICARE were low in comparison to the other locations surveyed.[29] To assist in this effort, the Assistant Secretary of Defense (ASD) for Health Affairs directed TMA's Communications and Customer Service Directorate to work with the TROs and other TMA officials to develop a strategic marketing plan for these locations.[30] The cities selected by the TROs are as follows:

- West region: Olympia, Washington (2,732 nonenrolled beneficiaries), Monterey, California (1,180 nonenrolled beneficiaries), Seattle,

[29]Eight of the locations were surveyed as HSAs in the 2005 civilian provider survey. One additional location, Anchorage, Alaska, was previously identified as an area with low civilian provider acceptance of nonenrolled beneficiaries during TMA's pilot of the survey in 2004.

[30]TMA has not specified a timeline for this task.

Washington (2,358 nonenrolled beneficiaries), and Anchorage, Alaska (3,381 nonenrolled beneficiaries);

- North region: Brooklyn, New York (4,276 nonenrolled beneficiaries) and Eau Claire, Wisconsin (902 nonenrolled beneficiaries); and
- South region: Arlington, Texas (3,025 nonenrolled beneficiaries), Houston, Texas (6,415 nonenrolled beneficiaries), and Boca Raton, Florida (447 nonenrolled beneficiaries).

TMA officials and TRICARE beneficiaries have stated that additional survey questions could have yielded useful information. For example, the survey did not ask providers whether they are accepting new Medicare patients—an important proxy because TRICARE reimbursement rates are established using Medicare reimbursement rates, and a comparison of the two programs could provide information on whether providers are more concerned with the amount of reimbursement or other issues.[31] Furthermore, the survey did not ask providers how much of their current practice consists of TRICARE beneficiaries, to capture whether or not providers may already have TRICARE beneficiaries in their practices. However, a provision in the NDAA for fiscal year 2006 instructs TMA to add the following questions to its civilian provider survey:

1. What percentage of Dr. X's current patient population uses any form of TRICARE?
2. Does Dr. X accept patients under the Medicare program?
3. Would Dr. X accept additional Medicare patients?[32]

TMA's Beneficiary Health Care Survey

In addition to its civilian provider survey that covered 20 states, TMA gathers worldwide information on nonenrolled TRICARE beneficiaries' access to care through its annual Health Care Survey of DOD Beneficiaries, which covers all TRICARE

[31]In *Medicare Fee-for-Service Beneficiary Access to Physician Services: Trends in Utilization of Services, 2000 to 2002*, GAO-05-145R (Washington, D.C.; Jan. 12, 2005), we evaluated two indicators of beneficiary access to Medicare physician services and found that although Medicare physician fees had been reduced by 5.4 percent in 2002, the indicators we evaluated suggested an increase in access to care.

[32]See Pub. L. No. 109-163, § 711, 119 Stat. 3136, 3343.

options.[33] According to survey results from 2003 through 2005, about 77 percent of nonenrolled TRICARE beneficiaries who obtained care reported that "getting needed care" was not a problem for them. Similarly, over 80 percent of these TRICARE beneficiaries reported that they could "get care quickly." For the same time period, TMA compared its survey results with the results of a civilian health plan survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®),[34] which asked participants the same questions on access to care under their plans. From this comparative analysis, TMA found that a similar percentage of civilian health plan participants—about 80 percent—responded that "getting needed care" was not a problem and that they could "get care quickly." TMA uses this survey as a benchmark to compare TRICARE against civilian plans.

Beneficiary Feedback

Anecdotal information about access to care is available through TMA's centralized Beneficiary and Provider Services office, which collects and monitors information on TRICARE beneficiaries' complaints and general inquiries, including issues about access to care. TRICARE beneficiaries may contact this office by telephone, e-mail, written correspondence, or through their congressional representatives. TMA officials broadly categorize each contact by issue and use this information to monitor trends in the feedback they receive through these contacts. A TMA official stated that if the number of contacts they receive related to an issue rises, the appropriate program officials—such as the TROs—are notified and encouraged to investigate the issue. Furthermore, TMA maintains a record of TRICARE beneficiary and provider contacts that have been addressed and those that remain open and continue to require attention. Although the Beneficiary and Provider Services office does not specifically track access-to-care issues as a separate issue, one of the TMA officials responsible for tracking the contacts told us that TRICARE beneficiary

[33]The Health Care Survey of DOD Beneficiaries was implemented in response to a requirement in the NDAA for fiscal year 1993 to annually survey beneficiaries of DOD's health care programs about their ability to access health care services and their satisfaction with the services they received, among other things. See 10 U.S.C. § 1071, note. TMA conducts this survey on a yearly basis using a representative sample of all TRICARE beneficiaries worldwide.

[34]CAHPS is a registered trademark of the Department of Health and Human Services' Agency for Healthcare Research and Quality. CAHPS refers to a family of surveys that asks consumers and patients to evaluate their health care using a standardized set of questions. The Centers for Medicare & Medicaid Services conducts a CAHPS survey of both the Medicare fee-for-service population and the Medicare Advantage population. Throughout this report we refer to the fee-for-service CAHPS® survey as the CAHPS survey.

complaints and inquiries relating to access issues have been minimal. Overall, concerns and inquiries for the "contractor service complaint" category, which could include access-to-care issues for both enrolled and nonenrolled TRICARE beneficiaries, represented about 1 percent of about 6,900 total contacts about the MCSCs for 2005.

In addition, on a regional level, the TROs collect and monitor TRICARE beneficiary feedback gathered from e-mails and phone calls, as well as correspondence they receive from TRICARE beneficiary groups. However, the TROs told us that detailed information on each of these contacts is not routinely maintained. For example, one TRO told us that when a TRICARE beneficiary contacts them for assistance in locating a provider, they track the general reason for the call, but do not document the specific concerns. TRO officials told us that they receive only a small number of contacts from nonenrolled TRICARE beneficiaries who are unable to obtain care from nonnetwork civilian providers.[35] For example, one TRO told us that they received approximately 34 requests for assistance locating a provider in calendar year 2005 from the over 600,000 nonenrolled TRICARE beneficiaries in this region. TRO officials indicated that sometimes these requests are due to TRICARE beneficiaries' inability to obtain care from a specific provider at a specific time and are not necessarily indicative of access problems because that provider may be available at another time or other providers may be available. The TROs told us that they also monitor nonenrolled TRICARE beneficiaries' access to care retrospectively by evaluating claims data as a record of health care usage. For example, the TROs use these data to identify how many network and nonnetwork providers have accepted nonenrolled TRICARE beneficiaries as patients and to evaluate the use of the different TRICARE options.

Finally, the TROs and military services are in the process of implementing a new method of monitoring TRICARE beneficiary feedback. The Assistance Reporting Tool (ART) is a computer database that when fully operational will be used to archive and manage TRICARE beneficiary feedback on all aspects of health care. Currently each of the three TROs, all Army MTFs, and a portion of Navy and Air Force MTFs use this system as either their primary or one of several tools for managing and archiving TRICARE beneficiary feedback.[36] Because ART is not mandatory for all

[35]The TROs acknowledge that the majority of TRICARE beneficiaries direct their concerns and inquiries to the MCSCs and not to the TRO.

[36]The office of the Army Surgeon General has mandated that all Army MTFs use the ART.

MTFs, the TROs also rely on other feedback mechanisms to capture the most complete record of TRICARE beneficiary concerns and questions. These other mechanisms include e-mails from TRICARE beneficiaries to MTFs and data requests that the TROs periodically make to MTFs. In addition, while the MCSCs are not required to use ART because it was introduced after TRICARE's current health care delivery contracts were awarded, one of the MCSCs is currently using it. In the next cycle of TRICARE contracts, TMA officials told us that they plan to require that all MCSCs use this system. TMA officials who have reviewed the preliminary information captured by ART told us that the tool has obtained very little feedback that would indicate nonenrolled TRICARE beneficiaries are having problems with access to care.

MCSCs Have Approaches for Monitoring Access to Care Though They Are Not Specific to Nonenrolled TRICARE Beneficiaries

Each of the three MCSCs has developed its own methods for monitoring whether TRICARE beneficiaries in its region have access to care both in Prime Service Areas and in areas where provider networks do not exist. According to the MCSCs, while their methods for evaluating access to care were not designed to evaluate access specifically for nonenrolled TRICARE beneficiaries, they do provide some information that they use to monitor the availability of both network and nonnetwork civilian providers for this population, which is one component of access to care.

The MCSCs also monitor access to care through beneficiary inquiries. Each maintains a data system to archive and tabulate anecdotal TRICARE beneficiary feedback received through some or all of the following methods: telephone, e-mail, congressional correspondence, or walk-in visits to a TRICARE Service Center. The MCSCs organize TRICARE beneficiary feedback into subject categories and then monitor changes in the frequency of contacts in these categories to identify trends and important issues. At our request, each of the MCSCs reviewed their most recent TRICARE beneficiary complaint data and found very small numbers of comments pertaining to health care access. The MCSCs told us this was an indication that TRICARE beneficiaries—both enrolled and nonenrolled—were not experiencing any widespread problems with access to care. For example, one MCSC identified fewer than 40 complaints related to access out of one million contacts with TRICARE beneficiaries in a 1-month period. The second MCSC reported that for the last two quarters of 2005 they received an average of 355 inquiries and complaints each month about access to care. Officials from this MCSC told us that while their TRICARE beneficiary feedback system could not quantify the total number of inquiries received, these 355 inquiries represented a small percentage of all contacts. The third MCSC reported

that out of more than 250,000 phone calls and walk-in visits to TRICARE Service Centers during the month of December 2005, 71 contacts, or less than 1 percent of the total contacts, were related to access.

The MCSCs also determine how many civilian providers have accepted at least one TRICARE beneficiary by analyzing claims data to examine the extent to which both network and nonnetwork civilian providers are accepting TRICARE beneficiaries as patients. Each MCSC has concluded that more than half of all licensed civilian providers—both network and nonnetwork—in their respective regions have accepted at least one TRICARE beneficiary, regardless of enrollment status, as a patient in the last year.[37] According to MCSCs, access to care appears to be generally sufficient because the percentage of all licensed civilian providers in each region who have submitted at least one TRICARE claim during the past year are as follows: 90 percent in the South region, where TRICARE beneficiaries represent 3.7 percent of the entire region's population; 56 percent in the West region, where TRICARE beneficiaries represent 3.1 percent of the region's population; and 52 percent in the North region, where all TRICARE beneficiaries represent an estimated 2.1 percent of the region's population.[38]

Each MCSC told us that one of the primary ways they ensure sufficient access to care for both enrolled and nonenrolled TRICARE beneficiaries is by monitoring whether their civilian provider networks have the capacity to provide care to all beneficiaries in their Prime Service Areas. Throughout the three regions, the majority of nonenrolled TRICARE beneficiaries—84 percent—live within Prime Service Areas, making the choice of using a civilian network provider through Extra a readily available option for them. In the South region, all TRICARE beneficiaries reside in Prime Services Areas. In this region, the MCSC monitors access to care through geographic analyses of provider and TRICARE beneficiary locations to determine whether its networks meet the needs of both enrolled and nonenrolled TRICARE beneficiaries using TRICARE's access standards. In another region, where not all TRICARE beneficiaries live in Prime Service Areas, the MCSC will assist nonenrolled TRICARE beneficiaries in finding nonnetwork civilian providers on an as-needed

[37]TRICARE beneficiaries did not seek care from all licensed civilian providers because in some areas TRICARE serves a small percentage of the general population.

[38]Our estimate excluded the census population of residents living in small portions of Iowa, Missouri, and Tennessee that are part of the North Region.

basis. In the third region where the Prime Service Areas also do not encompass all TRICARE beneficiaries, the MCSC recruits and contracts with providers outside of Prime Service Areas who are available and willing to deliver care to nonenrolled TRICARE beneficiaries living there. Network providers who deliver care in locations outside of Prime Service Areas currently account for 25 percent of this MCSCs' network providers.

Various Factors Impede Providers' Acceptance of Nonenrolled TRICARE Beneficiaries, and TMA and MCSCs Have Different Ways to Address Them

TMA, MCSCs, and provider representatives have cited various factors as impediments to civilian providers' willingness to accept nonenrolled TRICARE beneficiaries as patients, and TMA and its MCSCs have different ways to address them. Some impediments are specific to TRICARE, including concerns about reimbursement rates and administrative issues, and TMA and its MCSCs have specific ways to address these issues. For example, TMA has the authority to increase reimbursement rates in certain circumstances, and both TMA and MCSCs conduct outreach efforts targeted to assist civilian providers with administrative issues. Other impediments—such as providers' practices being at maximum patient capacity and provider shortages in certain locations—are not specific to TRICARE and are therefore inherently more difficult for TMA and the MCSCs to address.

Providers Cite Concerns about TRICARE's Reimbursement Rates as a Reason for Denying Nonenrolled TRICARE Beneficiaries' Access to Care, but TMA Has Authority to Adjust Rates When Needed

Since TRICARE was implemented in 1995, some civilian providers—both network and nonnetwork—have complained that TRICARE's reimbursement rates tend to be lower than those of other health plans, and as a result, some of these providers have been unwilling to accept nonenrolled TRICARE beneficiaries as patients. According to the results of the initial round of TMA's civilian provider survey, concern about reimbursement amounts was one of the primary reasons that both network and nonnetwork civilian providers cited for not accepting nonenrolled TRICARE beneficiaries as new patients. In the 2005 civilian provider survey, of those who gave reasons for not accepting nonenrolled TRICARE beneficiaries as new patients, 20 percent of network providers and 25 percent of nonnetwork providers cited concerns about reimbursement amounts. However, TMA has the authority to adjust reimbursement rates in areas where it determines that reimbursement rate amounts have been negatively impacting TRICARE beneficiaries' ability to obtain care.

Providers' Concerns about TRICARE Reimbursement Rates

One of providers' main reasons for not accepting nonenrolled TRICARE beneficiaries as patients is providers' concern about low reimbursement amounts. TRICARE's reimbursement rates generally mirror

reimbursement rates paid by the Medicare program. Beginning in fiscal year 1991,[39] in an effort to control escalating health care costs, Congress instructed DOD to gradually lower its reimbursement rates for individual civilian providers to mirror those paid by Medicare[40]—an adjustment that has saved hundreds of millions of dollars since the conversion.[41] As of January 2006, the transition to Medicare rates was nearly complete, and reimbursement rates for only 48 services remain higher than Medicare reimbursement rates. (See app. V for a list of these services.)

According to TMA and MCSC officials, civilian providers, including both network and nonnetwork, generally seek to develop a practice that includes patients with higher-paying private insurers to compensate for the acceptance of patients with lower-paying health plans, including Medicare, Medicaid, and TRICARE. However, according to TMA and MCSC officials, TRICARE generally has little leverage to encourage network and nonnetwork civilian provider acceptance of its patients because the TRICARE population is small and transient. Further, in locations where the demand for providers' services exceeds the supply—such as in Alaska—providers can be selective about who they accept as patients.

TMA and MCSC officials have also cited providers' concerns that TRICARE's pediatric and obstetric rates are lower than Medicaid rates for these services. To investigate these concerns, TMA conducted a comparative analysis that found TRICARE's reimbursement rates for selected pediatric and obstetric procedures were generally higher than Medicaid's rates in many states for March 2006. TMA compared the TRICARE reimbursement rate for the service most commonly billed by pediatricians—an office visit for an established patient—with Medicaid rates for this service and found that in 41 of the 45 states for which Medicaid data were available, the TRICARE reimbursement rate exceeded

[39]Prior to the implementation of TRICARE, DOD provided civilian health care to eligible beneficiaries under the Civilian Health and Medical Program of the Uniformed Services to supplement health care provided through MTFs.

[40]Congress specified that reductions were not to exceed 15 percent in a given year. See Department of Defense Appropriations Act for Fiscal Year 1991, Pub. L. No. 101-511, § 8012 104 Stat. 1856, 1877 (1990). This instruction was eventually codified at 10 U.S.C. § 1079(h).

[41]We previously evaluated the methodology used to transition to Medicare level of payment and concluded this methodology complies with statutory requirements and generally conformed with accepted actuarial practice in *Reimbursement Rates Appropriately Set; Other Problems Concern Physicians*, GAO/HEHS-98-80 (Washington, D.C.: Feb. 26, 1998).

Medicaid's rate for this service. In addition, TMA compared its reimbursement rates for 14 commonly used maternity and delivery services with Medicaid rates and found that in 35 of the 45 states for which Medicaid data were available,[42] TRICARE reimbursement rates for these services exceeded the Medicaid payment rates.

TMA also analyzed reimbursement rates for pediatric immunizations based on MCSCs' concerns that providers viewed these rates as too low. However, when TMA compared TRICARE's reimbursement rates with the cost of the vaccine for the 10 most frequently used pediatric vaccines and for the hepatitis A vaccine, TMA's analysts concluded that the TRICARE reimbursement rates were generally reasonable and not undervalued in relation to what a provider might actually pay to obtain them. Only one vaccine—the pediatric hepatitis A vaccine—appeared to be priced lower than the reasonable cost of obtaining the vaccine. In this instance, the TRICARE reimbursement rate was $22.64, while pediatricians were paying between $27.41 and $30.37 for the vaccine. As a result of this discrepancy, TMA used its general authority to deviate from Medicare rates,[43] and starting May 1, 2006, TMA instructed the MCSCs to reimburse pediatric hepatitis A vaccines nationally at a new reimbursement rate of $30.40.

TMA Has Authority to Use Waivers to Adjust Reimbursement Rates

TMA has the authority to increase TRICARE reimbursement rates for network and nonnetwork civilian providers to ensure that all beneficiaries, including nonenrolled beneficiaries, have adequate access to care. TMA's authorities include (1) waiving reimbursement rate reductions for both network and nonnetwork providers that resulted when TRICARE reimbursement rates were lowered to Medicare levels,[44] (2) issuing locality waivers that increase rates for specific procedures in specific localities,[45] and (3) issuing network-based waivers that increase some network civilian providers' reimbursements.[46] Once implemented, waivers remain in effect indefinitely until TMA officials determine they are no longer needed. As of August 2006, TMA had approved 15 waivers in total—2 waiving

[42]Two states do not have fee-for-service Medicaid programs. The remaining three states and the District of Columbia did not provide data on Medicaid reimbursements.

[43]See 10 U.S.C. § 1079(h)(1).

[44]32 C.F.R. § 199.14(j)(1)(iv)(C).

[45]32 C.F.R. § 199.14(j)(1)(iv)(D). According to a TMA official, TMA usually defines a locality using one or more zip codes.

[46]32 C.F.R. § 199.14(j)(1)(iv)(E).

reimbursement rates reductions that resulted when TRICARE reimbursement rates were lowered to Medicare levels, 7 locality waivers, and 6 network waivers.

TMA can use its authority to waive reimbursement rate reductions to restore TRICARE reimbursement rates in specific localities to the levels that existed before a reduction was made to align TRICARE rates with Medicare rates. On two occasions, TMA has used this authority in Alaska to encourage both network and nonnetwork civilian providers to accept TRICARE beneficiaries as patients in an effort to ensure adequate access to care. In 2000, TMA used this waiver authority to uniformly increase reimbursement rates for network and nonnetwork civilian providers in rural Alaska, and in 2002 TMA implemented this same waiver for network and nonnetwork civilian providers in Anchorage. The use of these waivers resulted in an average reimbursement rate increase of 28 percent for all of Alaska. However, in 2001, we studied the effect of the 2000 waiver on access to care in rural Alaska and found that it did not increase TRICARE beneficiaries' access to care.[47]

Locality waivers may be used to increase rates for specific medical services in specific areas where access to care has been severely impaired. Reimbursement rate increases for this type of waiver can be established in one of three ways: by adding a percentage factor to the existing TRICARE reimbursement rate, by calculating a prevailing charge,[48] or by using another government reimbursement rate, such as rates used by the Department of Veterans Affairs to purchase health care from civilian providers. The resulting rate increase would be applied to both network and nonnetwork civilian providers for the medical services identified in the areas where access is severely impaired. A total of nine applications for locality-based waivers have been submitted to TMA between January 2003 and August 2006. (See table 4.) Of these, seven locality waivers have been approved by TMA and two are still pending. Six of the approved locality waivers as well as one pending application are for locations in Alaska. This includes one approved waiver to adjust the reimbursement rates for obstetric services to match Medicaid rates in Alaska and nine

[47]See *Across-the-Board Physician Rate Increases Would be Costly and Unnecessary*, GAO-01-620 (Washington, D.C.: May 24, 2001).

[48]Prevailing charges are commonly used charges that fall within the range of charges most frequently and widely used by providers in a locality for a particular procedure or service.

additional states based on TMA's comparative analysis of reimbursement rates for 14 obstetrical procedures.

Table 4: Applications for Locality Waivers and Approval Results

Date submitted	Affected location	Affected services	Amount of increase requested	Status
1/23/03	Juneau, AK	All gynecological procedures or services delivered by one provider	600 percent[a]	3/26/03—Approved for nonroutine gynecological procedures or services
8/2004	Fairbanks, AK	All inpatient internal medicine procedures or services delivered by providers employed by Fairbanks Memorial Hospital	Veterans Administration rates[b]	10/28/04—Approved
6/08/05	Anchorage, AK	All medical procedures or services delivered by perinatologists	40 percent	11/21/05—Approved for perinatologists who are participating providers[c]
6/08/05	Fairbanks, AK	Four medical procedures or services delivered by two plastic surgeons	175-253 percent	5/18/06—Approved to increase rates to the rate paid by the Veterans Administration for professional services provided by plastic surgeons in Alaska
3/03/05	Puerto Rico[d]	All medical procedures or services delivered by neurosurgeons	40 percent	10/26/05—Approved
10/19/05	Alaska, Arizona, Connecticut, Montana, Nevada, Oregon, South Carolina, Washington, West Virginia, Wyoming.[e]	14 obstetrical procedures or services	Medicaid reimbursement amounts	03/20/06—Approved
2/23/06	Fairbanks, AK	All anesthesia or pain management and treatment services delivered by anesthesiologists	200 percent	6/02/06—Approved to increase rates by 252 percent[f]
3/06/06	Puerto Rico[d]	Five high-risk medical procedures or services delivered by obstetricians; multiple medical procedures or services delivered by orthopedists and urologists	Various: Between 160 percent and 460 percent for obstetricians; 300 percent for orthopedists; and 162 percent for urologists	Pending
7/2006	All of Alaska	All medical services or procedures	Veterans Administration rates[b]	Pending

Source: DOD.

[a]Request did not include a specific increase amount. The approved waiver was for the lesser of billed charges or 600 percent of the TRICARE reimbursement rate.

[b]TMA agreed to match the Department of Veterans Affairs reimbursement rates for these procedures.

[c]Participating providers submit claims for reimbursement and are not permitted to bill TRICARE beneficiaries an additional 15 percent above the TRICARE reimbursement rate.

[d]The TROs are not responsible for managing TRICARE in Puerto Rico because it operates under a different contract than used for the threeTRICARE regions.

[e]When reviewing the need for this rate adjustment, TMA compared TRICARE reimbursement rates with Medicaid rates in 45 states for which data were available. The 10 states listed were identified as needing a rate adjustment based on this analysis. Each year when the TRICARE reimbursement rates are adjusted, TMA intends to similarly determine where this adjustment is needed.

[f]Because the TRICARE reimbursement rate changed during the period between the application and the approval of this waiver, TMA raised the percentage of the increase.

Network waivers are used to increase reimbursement rates for network providers up to 15 percent above the TRICARE reimbursement rate in an effort to ensure an adequate number and mix of primary and specialty care network civilian providers for a specific location. Between January 2002 and August 2006, 10 applications for network waivers have been submitted to TMA. Of these, 6 network waivers have been approved by TMA and 4 have been denied. (See table 5.)

Table 5: Applications for Network Waivers and Approval Results

Date submitted	Affected location	Affected services	Amount of increase requested	Status
1/29/02	Fredricksburg, VA	33 varied medical procedures or services, encompassing various specialties	28 percent[a]	Denied—Application did not substantiate an access to care problem
3/07/02	Great Falls, MT	All medical procedures or services delivered by a specific clinic representing 32 specialties	200 percent[a]	Denied—Application did not directly request a network waiver and increase could be handled under TRICARE Prime Remote[b]
8/13/02	Idaho	All medical procedures and services	15 percent	1/15/03—Approved for nine specialties in the Mountain Home Air Force Base Prime Service Area
12/20/02	Bozeman, MT	All obstetrical or gynecological medical procedures or services	15 percent	Denied—Increase available under TRICARE Prime Remote[b]
4/08/03	Cheyenne, WY	Three newborn inpatient medical procedures or services	To match civilian insurers' rates	7/16/03—Approved increase to 15 percent above TRICARE reimbursement rates
2/03 and 3/03	Watertown, NY Norwich, CT	Deliveries provided by nurse midwives in NY and emergency gynecological services in CT	Not specified	Denied–Incomplete application package submitted
9/26/03	Ft. Leonard Wood and Springfield, MO	All medical procedures and services delivered by network providers	15 percent	12/24/03—Approved for 11 specialties in Ft. Leonard Wood Prime Service Area Denied for Springfield
1/05/05	Delta Junction and Tok, AK	All primary care medical procedures and services	15 percent	3/30/05—Approved for nonmental health medical care services, excluding laboratory services
6/10/05	Norfolk, VA	All medical procedures and services for three specialties delivered by a group of pediatric specialists	15 percent	7/08/05—Approved
3/06/06	Rapid City, SD	All obstetrical or gynecological services delivered by a group of specialists	Not specified	5/16/2006—Approved a 15 percent increase for one group of obstetricians and gynecologists

Source: DOD.

[a]According to TMA, the waiver requesters did not understand that the maximum network waiver is 15 percent over TRICARE reimbursement rates. If the waiver had been granted it would have been limited to 115 percent of the TRICARE reimbursement rate.

[b]TRICARE Prime Remote is a specialized version of TRICARE Prime available for active duty members when they are assigned to duty stations in areas not served by the military health care system. Under this program, civilian network providers can be reimbursed up to 15 percent above the TRICARE reimbursement rate. Family members who reside with service members who are enrolled in TRICARE Prime Remote are eligible to enroll in and receive care under TRICARE Prime Remote for Active Duty Family Members.

Providers, TRICARE beneficiaries, MCSCs, as well as TRO directors may apply for a reimbursement rate waiver by submitting written requests supporting the need for reimbursement rate increases on the grounds that access to health care services is impaired due to low reimbursement rates. These requests must contain specific justifications to support the claim that access problems are related to reimbursement rates and must include information such as the number of providers and TRICARE beneficiaries in a location, the availability of MTF providers, geographic characteristics, and cost effectiveness of granting the waiver. All waiver requests are submitted to the TRO directors, who review the application and make a decision whether to forward the request to the Director of TMA through TMA's contracting officers, who are responsible for administering the MCSCs' contracts. According to a TMA official, the contracting officers work with TMA analysts to review the submitted requests and verify whether there is an insufficient number of providers in the area and conduct a cost-benefit analysis before making a recommendation to the Director of TMA that the waiver be accepted or denied. Each analysis is tailored to the specific concerns outlined in the waiver requests. According to this official, TMA conducts these additional analyses to ensure that an increase in reimbursement rates would actually alleviate access problems and that access was not impaired due to such things as administrative problems or providers' unhappiness with claims payment timeliness or accuracy.

Once a waiver is granted, there is no mechanism that automatically terminates it. According to a TMA official, there was an expectation within TMA that the continued need for existing waivers would be evaluated on an annual basis.[49] However, waivers have been reviewed on a periodic, ad hoc basis rather than on an annual basis as expected. When TMA implemented new MCSC contracts in fiscal years 2004 and 2005, TMA and

[49]The regulation authorizing locality waivers based on severe impairment of access states that those decisions are "subject to review and determination or modification at any time … if circumstances change so that adequate access to health care services would no longer be severely impaired." See 32 C.F.R. § 199.14(j)(1)(iv)(D)(1). The regulations for the other two waivers do not specifically address review.

the MCSCs discussed existing waivers and mutually agreed to extend all of them because they continued to believe that these waivers were necessary to ensure access to care. However, without a formal analysis of how these waivers have impacted access in the areas in which they were implemented, the actual extent of their effect is unclear.

Providers Cite Concerns About TRICARE's Administrative Issues as Reasons for Not Accepting Nonenrolled TRICARE Beneficiaries, but MCSCs Use Various Methods to Address These Concerns

Since the inception of TRICARE, both network and nonnetwork civilian providers have expressed concerns about administrative issues or "hassles" associated with the program, which, when combined with low reimbursement rates, make them less likely to accept nonenrolled TRICARE beneficiaries as patients. TMA and MCSC officials stated that because TRICARE beneficiaries usually represent only a small percentage of a provider's practice, both network and nonnetwork civilian providers may not be as knowledgeable about the program and its unique administration requirements. Adding to the potential for confusion, while some administrative requirements apply to all TRICARE beneficiaries, the TRICARE program also has separate and distinct administrative requirements for enrolled and nonenrolled TRICARE beneficiaries. For example, network providers must meet specific time frame and documentation requirements when referring enrolled TRICARE beneficiaries for specialty care or when delivering specialty care to enrolled TRICARE beneficiaries. However, referral standards usually do not apply to nonenrolled TRICARE beneficiaries. Additionally, according to the initial round of TMA's civilian provider survey, 15 percent of network respondents and 7 percent of nonnetwork respondents who gave explanations for why they were not accepting nonenrolled TRICARE beneficiaries as new patients cited administrative inconveniences as a reason. These administrative inconveniences included too much paperwork, problems understanding the benefits and policies, and a lengthy referral process.

MCSC and TMA officials also told us that providers' past experiences with TRICARE administrative issues may have biased their opinion of the program, while, in some cases, there have been improvements. For example, according to MCSCs and TMA officials, some providers perceive that previously identified claims processing problems persist and cite problems with timeliness and claims payment decisions as reasons for not accepting TRICARE patients. While claims processing problems plagued the TRICARE program in its early years, we reported in 2003 that efforts

had been made to improve claims processing efficiency, and as a result, claims were being processed in a more timely manner, though some inefficiencies remained.[50] In addition, some TRO officials and providers said that TRICARE claims payment decisions sometimes are not always clear to providers and, as a result, they may believe problems with claims processing exist. This is due in part to the fact that TRICARE's claims processing outcomes may differ from Medicare's—despite the programs' similarities in reimbursement rates—due to different benefit structures and different claims processing tools that are used to prevent overpayment. Furthermore, because they do not always understand the program, providers and TRICARE beneficiaries may complain about adjudication decisions on claims that have been processed correctly. Problems may also occur because providers and TRICARE beneficiaries may make mistakes when filing their claims.

In efforts to address problems related to administrative issues, MCSCs conduct a variety of outreach efforts to educate nonnetwork civilian providers on TRICARE requirements and assist with both actual and perceived administrative concerns. For example, MCSCs provide on-line tools and toll-free telephone support to mitigate administrative issues. Also, one MCSC works with state medical associations to address provider concerns and to ensure that information about TRICARE requirements is included in medical association newsletters. Each of the MCSCs has provider relations representatives located in areas throughout the region outside of their central office. These provider relations representatives schedule opportunities to meet with nonnetwork civilian providers that include booths or speaking engagements at health fairs, conferences, and other provider events and, when necessary, work one-on-one with network and nonnetwork civilian providers to provide instructions on ways to respond to TRICARE's administrative requirements and to help eliminate the burden of unnecessary paperwork. According to MCSCs, these efforts have been helpful because they are not experiencing widespread problems with TRICARE beneficiaries' access to care. However, similar to the use of waivers, the actual extent to which these efforts have improved access to care is unclear.

[50]See GAO, *Defense Health Care: TRICARE Claims Processing Has Improved but Inefficiencies Remain*, GAO-04-69 (Washington, D.C.: Oct. 15, 2003).

Though TMA and MCSCs Attempt to Address Impediments That Are Not Specific to TRICARE, These Issues Cannot Always be Resolved

TMA and MCSCs attempt to address impediments to network and nonnetwork provider acceptance of nonenrolled TRICARE beneficiaries that are not specific to the TRICARE program. However, TMA and MCSCs cannot always resolve access problems related to these impediments. Some network and nonnetwork civilian providers may be unwilling to accept TRICARE beneficiaries as patients because their practices are already at capacity. For example, the initial round of TMA's civilian provider survey found that 14 percent of providers in the 20 states surveyed were not available to accept any new patients, including TRICARE patients, privately insured patients, or patients who were paying for their own care. According to the MCSCs, access problems related to practice capacity are more likely to occur in geographically remote areas that have few providers than in more densely populated areas with more providers. However, one MCSC stated that access problems related to practice capacity can also occur in urban areas where the medical needs of the population exceed the supply of specific specialties, such as dermatology.

TRICARE beneficiaries' access to care is also impeded in areas where there are insufficient numbers and types of civilian providers, both network and nonnetwork, to cover the local demand for health care. In these locations, the entire community is impacted by provider shortages. Consequently, TRICARE beneficiaries, as well as all other local residents, must sometimes travel long distances to obtain health care. MCSC officials stated that each TRICARE region includes areas with civilian provider shortages. For example, in TRICARE's North Region, Watertown, New York, has an insufficient number of certain specialty providers for its population, which includes TRICARE beneficiaries stationed at a nearby military installation whose MTF is too small to handle all of their health care needs. TRICARE's South Region contains many rural areas with few providers, including multiple locations in Oklahoma and Texas. Likewise, in TRICARE's West Region, MCSC officials stated that there are provider shortages in various locations, including Cheyenne, Wyoming, and Mountain Home, Idaho.

TMA and the MCSCs have limited means of responding to access-to-care impediments in areas with network and nonnetwork civilian provider shortages, although TMA has adopted two bonus payment systems that

mirror those used by Medicare for these areas.[51] In June 2003, TMA began paying providers a 10 percent bonus payment for the services rendered in Health Professional Shortage Areas, which the Department of Health and Human Services has identified as having a shortage of primary care, dental, or mental health providers.[52] Also, in January 2005, TMA followed Medicare in initiating payment of a 5 percent bonus for services rendered by primary care providers in geographic areas designated by the Department of Health and Human Services as Physician Scarcity Areas,[53] a program that is only operational through 2007.[54] Providers who are eligible for and wish to receive either of these bonus payments must include a specific code on every claim they submit to obtain these additional payments. According to a TMA official, TMA does not know the extent to which these payments have been used and has not evaluated the effectiveness of these bonus payments on access to care.

TMA and the MCSCs have attempted to overcome obstacles related to practice capacity and provider shortages by using high-ranking military personnel and field provider relation representatives to make personal appeals to network and nonnetwork civilian providers. In August 2004, the ASD for Health Affairs wrote a letter to providers appealing to their patriotism and asking them to accept TRICARE beneficiaries as patients. One MCSC official claimed that this letter has resulted in additional providers accepting both enrolled and nonenrolled TRICARE beneficiaries as patients. In addition, in certain areas where access is problematic, MCSC provider relations representatives or TRO officials personally call on providers to solicit their support of military personnel through TRICARE.

[51]TMA has the authority to implement bonus payment programs for physicians in areas determined to be medically underserved areas by the Department of Health and Human Services for Medicare purposes. TMA is required to make the bonus payments in the same amounts as authorized for Medicare. See 32 C.F.R. § 199.14(j)(2).

[52]See 42 U.S.C. § 1395l(m). Health Professional Shortage Area designations are based on shortages of primary medical care, dental, or mental health providers and may be rural or urban areas, population groups, or medical or other public facilities.

[53]Physician Scarcity Area designations are based on the calculation of the ratios of active providers of primary and specialty care to Medicare beneficiaries in every county in the United States. See 42 U.S.C. § 1395l(u).

[54]The Medicare bonus payment program for Physician Scarcity Areas expires at that time.

NDAA Responsibilities for Nonenrolled TRICARE Beneficiaries' Access to Care Are Being Carried Out by TMA and the MCSCs, but Were Not Formally Designated to a Senior Official

Various TMA offices, including the TROs, and the MCSCs are carrying out the responsibilities that are outlined in the NDAA for fiscal year 2004 to take actions to ensure nonenrolled beneficiaries' access to care, such as educating civilian providers and recommending reimbursement rate adjustments—though these responsibilities were not formally designated to a single, senior official. For example, TMA's Communications and Customer Service Directorate has primary responsibility for education and marketing activities for all civilian providers—including nonnetwork providers—although the TROs and MCSCs also share this responsibility. (See table 6.) This office oversees a national contract for marketing and education materials with input from the TROs and the MCSCs. As part of this responsibility, this office designs and prepares marketing and education materials in conjunction with its contractor. On a regional level, the TROs and MCSCs also have responsibilities for educating both network and nonnetwork civilian providers. As part of these efforts, each TRO works with its region's MCSC to host town-hall meetings and to provide briefings for network and nonnetwork civilian providers. In addition, the MCSCs contact, support, educate, and market to both network and nonnetwork civilian providers. For example, one MCSC distributes its monthly provider newsletter or bulletin to nonnetwork civilian providers who submit 25 or more TRICARE claims in 1 year. MCSCs also provide educational materials to civilian providers, including nonnetwork providers, and, in some instances, schedule provider seminars for nonnetwork providers.

Table 6: Responsibilities Outlined in the NDAA for Fiscal Year 2004 and the Entities Covering Them

Responsibilities	Entities
Educate nonnetwork civilian providers about Standard	• TMA's Communications and Customer Services Directorate • TROs • MCSCs
Encourage nonnetwork civilian providers to accept nonenrolled TRICARE beneficiaries as patients under Standard	• MCSCs[a]
Ensure that nonenrolled TRICARE beneficiaries have information necessary to locate nonnetwork providers readily	• TMA • TROs • MCSCs
Recommend adjustments in provider reimbursement rates to ensure adequate availability of nonnetwork providers for nonenrolled TRICARE beneficiaries	• TROs[b]

Source: GAO analysis of DOD information.

[a]MCSCs solicit nonnetwork providers to accept TRICARE beneficiaries when nonenrolled TRICARE beneficiaries cannot locate providers in a specific location.

[b]Although the TROs are responsible for preparing and submitting justification for payment waivers, other interested parties, including MCSCs, providers, and TRICARE beneficiaries can submit requests for payment adjustments through the TROs.

Actions to encourage both network and nonnetwork civilian providers to accept nonenrolled TRICARE beneficiaries as patients are currently being addressed by the MCSCs. First, in areas with network civilian providers, MCSCs are required by contract to ensure that the networks are robust enough to provide health care to both enrolled and nonenrolled TRICARE beneficiaries in that location. As a result, MCSCs strive to ensure adequate numbers of network civilian providers who could also provide care to nonenrolled TRICARE beneficiaries. In addition, when nonenrolled TRICARE beneficiaries request assistance with finding providers, MCSCs work to encourage civilian providers, who could be either network or nonnetwork, to accept these TRICARE beneficiaries as patients. In some instances when a provider cannot be easily identified for a TRICARE beneficiary, MCSCs told us their provider relations representatives, who are knowledgeable about providers in their regions, will call on individual providers to encourage them to accept these TRICARE beneficiaries as patients. Nonetheless, as contractually required, MCSCs are focused on recruiting civilian providers for their networks and do not proactively recruit nonnetwork civilian providers to accept TRICARE beneficiaries as patients. Efforts to obtain nonnetwork civilian providers for nonenrolled

TRICARE beneficiaries using the Standard option are initiated on an as-needed basis.

Additionally, TMA, its TROs, and the MCSCs all have procedures and tools in place aimed at ensuring that nonenrolled TRICARE beneficiaries can readily locate both network and nonnetwork civilian providers. A central TMA office maintains an online directory of both network and nonnetwork civilian providers who have accepted TRICARE beneficiaries as patients in the last 2 years. MCSCs' Web sites provide a link to this TMA directory and also provide a directory of network civilian providers in their regions. Also, the TROs provide services, including assistance with locating civilian providers, to any TRICARE beneficiary who contacts them. Among other services they provide, Beneficiary Service Representatives at MCSC-operated TRICARE Service Centers assist "walk-in" TRICARE beneficiaries—regardless of their enrollment status—to locate providers. In addition, all MCSCs are contractually required to have representatives available by phone 24 hours a day, 7 days a week to assist with locating a network provider. One MCSC told us that if a network provider is not available, the phone representatives will help locate nonnetwork providers in the area.

Finally, the TROs currently are responsible for recommending reimbursement rate adjustments—that have been initiated by their offices, MCSCs, providers, and TRICARE beneficiaries—to increase provider reimbursement rates in areas where access to care is impaired for both enrolled and nonenrolled TRICARE beneficiaries. Since the TROs were established in 2004, two of the three TROs have recommended such increases to provider reimbursement rates in their regions.[55]

Nonetheless, TMA has not formally designated a senior official to take responsibilities for nonenrolled TRICARE beneficiaries and nonnetwork civilian providers as outlined in the NDAA for fiscal year 2004. According to TMA officials, this role was assumed by the ASD for Health Affairs, who is responsible for overseeing DOD's health programs and resources, because these responsibilities are included in the official directive for this position.[56] According to senior TMA officials, the ASD for Health Affairs

[55]Prior to the establishment of the TROs, regional offices, referred to as Lead Agents, were responsible for coordinating and submitting waiver request packages.

[56]DOD Directive 5136.1, which describes the responsibilities, functions, relationships, and authorities of the ASD for Health Affairs, would include these responsibilities.

intended to delegate these responsibilities to the TRO directors. However, while this intent was communicated verbally, the delegation was never formalized in writing. TRO officials told us that while they were aware of the ASD for Health Affairs' intent, they never received official notification or designation outlining these responsibilities and expectations. As a result, at the time of our site visits, the TROs had not undertaken any efforts beyond the level of assistance they were already providing to nonenrolled TRICARE beneficiaries and nonnetwork civilian providers.[57] Nonetheless, during the time of our review, each TRO was in the process of assigning responsibilities for nonenrolled beneficiaries to a specific staff member in accordance with the staffing plan TMA established for the TROs. Additionally, officials at each of the TROs told us that they provide services and assistance to all TRICARE beneficiaries regardless of enrollment status.

To more directly assign responsibilities for nonenrolled beneficiaries' access to care to the TROs, the NDAA for fiscal year 2006 specifically instructs the TROs to (1) identify nonnetwork providers who will accept nonenrolled TRICARE beneficiaries as patients; (2) communicate with nonenrolled TRICARE beneficiaries; (3) conduct outreach to nonnetwork providers, encouraging their acceptance of TRICARE beneficiaries as patients; and (4) publicize which nonnetwork providers in each region accept nonenrolled TRICARE beneficiaries as patients.[58] It also requires that DOD submit annual reports to Congress on efforts to implement these activities.

Agency Comments and Our Evaluation

We received comments on a draft of this report from DOD (see app. VI). In its comments DOD stated that it appreciated the collaborative, insightful, and thorough approach that was taken with this important issue. However, DOD disagreed with our finding that it had not formally designated a senior official to ensure nonenrolled beneficiaries' access to care, including adequate participation by nonnetwork providers, as required by the NDAA for fiscal year 2004. DOD stated that DOD directive 5136.12 assigned these duties to the TMA director and the TROs by designating the TMA Director as the program manager for TRICARE health and medical

[57]Since the NDAA for 2006, which tasked the TROs with responsibility for monitoring, oversight, and improvement of the Standard option within their respective regions, all three TROs have undertaken a number of new initiatives to meet these responsibilities.

[58]See Pub. L. No. 109-163, § 716, 119 Stat. 3136, 3345.

resources and other responsibilities. DOD stated that this responsibility clearly encompasses provision of care to nonenrolled beneficiaries and therefore meets the NDAA requirement.

We continue to believe that DOD has not adequately addressed the requirement in the mandate. First, in multiple interviews and e-mail exchanges during our audit work, senior DOD officials told us that no specific actions had been taken to designate a senior official and that, by default, the duties fell to the ASD for Health Affairs who is responsible for overseeing DOD's health programs and resources. Further, during our site visits, TRO officials told us they had never been officially notified of their responsibilities and expectations for nonenrolled beneficiaries and nonnetwork providers. As a result, at the time of our site visits the TROs told us they had not undertaken any efforts beyond the level of assistance they had already been providing to nonenrolled beneficiaries and nonnetwork civilian providers. Second, we do not agree with DOD that the terms of the pre-existing directive satisfy the requirements of the mandate. Contrary to the requirement in the law that one official be designated, the directive generally assigns responsibilities to TMA, as well as to multiple TROs on a geographic basis. While part of the TROs' responsibilities include developing a plan for the delivery of healthcare within the geographic region, the mandate contemplated a more global approach to addressing provider participation, specifically requiring one senior official to ensure provider participation in each market area.

DOD also provided technical comments that we incorporated where appropriate.

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov. If you or your staff have questions about this report, please contact me at (202) 512-7119. Contact points for our Office of

Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions are listed in appendix VII.

Marcia Crosse
Director, Health Care

Appendix I: Scope and Methodology

The National Defense Authorization Act (NDAA) for fiscal year 2004 directed GAO to review the processes, procedures, and analysis used by the Department of Defense (DOD) to determine the adequacy of the number of network and nonnetwork civilian providers and the actions taken to ensure access to care for nonenrolled TRICARE beneficiaries. Specifically, this report describes (1) how TRICARE Management Activity (TMA) and its managed care support contractors (MCSC) evaluate nonenrolled TRICARE beneficiaries' access to care and the results of these evaluations; (2) the impediments to civilian provider acceptance of nonenrolled TRICARE beneficiaries, and how they are being addressed; (3) how DOD has implemented the fiscal year 2004 NDAA requirements to take actions to ensure nonenrolled TRICARE beneficiaries' access to care.

TMA and MCSCs' Evaluation of Nonenrolled Beneficiaries' Access to Care and the Status of Access

To describe how TMA evaluates nonenrolled TRICARE beneficiaries' access to care, we interviewed and obtained documentation from officials in TMA's Health Program Analysis and Evaluation Directorate about its civilian provider survey, called the Survey on Continued Viability of TRICARE Standard. Although DOD was required to conduct a survey to assess nonenrolled beneficiaries' access to care under the Standard option, the survey was administered to both network and nonnetwork civilian providers since nonenrolled beneficiaries can receive care from these providers under both the Extra and Standard options. We reviewed the survey methodology, including the methods for selecting respondents, the survey's response rate,[1] the designation of TRICARE market areas, and the survey instrument itself. We also reviewed TMA's methods for randomly sampling market areas and providers and their administration of the survey instrument and found these decisions methodologically sound and statistically valid. In addition, we reviewed the survey results, including the published results and analysis. While we did not independently validate the survey data, we did assess the reliability of the data by reviewing survey documentation and internal controls and by interviewing knowledgeable agency officials and found that the data were sufficiently reliable for our purposes. To obtain information on how the civilian provider survey was developed, we interviewed officials at the Office of Management and Budget (OMB) because the Paperwork Reduction Act required OMB approval before it could administered. We also interviewed TRICARE beneficiary group representatives who had recommended sites for inclusion in the survey where nonenrolled

[1]The survey had a 55 percent response rate.

TRICARE beneficiaries' access to health care may be impaired. To identify how the civilian provider survey results would be used to evaluate access to care, we met with officials of TMA's Office of Health Plan Operations, the director of TMA's Standard Programs Division, and officials from the three TRICARE Regional Offices (TROs).

We also reviewed TMA's annual Health Care Survey of Defense Beneficiaries and compared it with a survey conducted by the Department of Health and Human Services' Consumer Assessment of Health Care Providers and System of individuals who received health care through civilian health insurers. These surveys include identical questions on access-to-care issues that allowed for comparative analysis of the opinions expressed by TRICARE beneficiaries and civilian health plan users. Using data from the 2003-2005 surveys we analyzed nonenrolled TRICARE beneficiaries' responses to access to care and compared them with results from the Consumer Assessment of Health Care Providers and Systems. We did not independently verify the data from each of these surveys; however, we did assess the reliability of these data by reviewing related documentation and interviewing knowledgeable agency officials and found that they were sufficiently reliable for our purposes.

To further identify and describe other methods TMA and MCSCs used to evaluate care access for nonenrolled TRICARE beneficiaries, we met with officials of TMA, the TROs, MCSCs, and each of the services' Office of the Surgeon General to obtain information on the systems they use for monitoring TRICARE beneficiary feedback and conducting other types of analyses, such as monitoring health care claims. The TROs and military services provided information on the Assistance Reporting Tool, a system that is being developed to monitor and archive TRICARE beneficiary feedback. The MCSCs also shared information about their independent systems for maintaining TRICARE beneficiary feedback. TMA, MCSC, and military service officials provided us with examples of TRICARE beneficiary feedback reports and health care claims data for nonenrolled TRICARE beneficiaries that TMA uses to evaluate access to care for this population. We did not independently verify data from the MCSCs' TRICARE beneficiary feedback systems and TMA's claims data files; however, we did assess the reliability of these data by interviewing knowledgeable officials and reviewing previous GAO work using these data and found that they were sufficiently reliable for our purposes. To identify how the MCSCs monitor access to care both in Prime Service Areas and in areas where networks have not been established, we obtained information about their techniques for network development and for civilian provider recruitment.

Impediments to Provider Acceptance of Nonenrolled TRICARE Beneficiaries and How They Are Being Addressed

To identify and describe the impediments to providers' acceptance of nonenrolled TRICARE beneficiaries, we obtained information from TMA Health Plan Operations, TMA Health Program Analysis and Evaluation Directorate, TRO, and MCSC officials on the possible reasons that providers were unwilling to accept nonenrolled TRICARE beneficiaries as patients. We also met with representatives of TRICARE beneficiary groups and the American Medical Association to obtain anecdotal information about impediments to health care access and to supplement our data on possible access-to-care problems.

To identify and describe how impediments, such as TRICARE reimbursement rates and administrative issues, are being addressed, we reviewed TRICARE's reimbursement policies and authorities as well as provider outreach strategies and marketing and education efforts of TMA and its MCSCs. We also reviewed the procedures for issuing waivers used to increase reimbursement rates in areas where TMA determines that access to care is impaired, including the application, review, and decision process. We then obtained information from TMA's Office of Medical Benefit and Reimbursement Systems on all of the completed and pending requests for reimbursement waivers. Finally, we interviewed MCSC and TRO officials to identify the administrative issues that impact provider acceptance of TRICARE beneficiaries and how they conduct outreach efforts to alleviate problems and/or educate providers about these issues. However, we did not assess the extent to which these efforts improved civilian providers' acceptance of nonenrolled beneficiaries as patients.

DOD Implementation of NDAA Fiscal Year 2004 Requirements for Oversight of Nonenrolled Beneficiaries' Access to Care

To examine how DOD has implemented the NDAA fiscal year 2004 requirements for oversight of nonenrolled TRICARE beneficiaries' access to care, we reviewed pertinent sections of this legislation outlining the tasks that DOD must perform to comply with the law. We interviewed officials in TMA's office of Health Plan Operations, the director of the TRICARE Standard Programs Division, and officials in each of the TROs. To identify whether and how the oversight responsibilities outlined in the NDAA were being managed, we obtained information from TRO and MCSC officials for each of the three regions and TMA's Communications and Customer Service Directorate to identify activities in place to educate network and nonnetwork providers about TRICARE Standard, to encourage network and nonnetwork providers to treat nonenrolled TRICARE beneficiaries, and to ensure that nonenrolled TRICARE beneficiaries have the information necessary to locate providers readily.

We conducted our work from July 2005 through December 2006 in accordance with generally accepted government auditing standards.

Appendix II: Methodology Used for TMA's Civilian Provider Survey

The National Defense Authorization Act (NDAA) for fiscal year 2004 required that the TRICARE Management Activity (TMA) conduct surveys in TRICARE market areas within the United States to determine how many health care providers are accepting new patients under TRICARE Standard in each market area. The NDAA did not stipulate how TMA should define a market area but specified that 20 market areas should be completed each fiscal year until all market areas in the United States have been surveyed. Although the mandate focused on Standard, TMA officials designed the survey to monitor access to care from both network and nonnetwork providers since nonenrolled TRICARE beneficiaries can receive care through both the Standard and Extra options.

Before TMA could begin administering the civilian provider survey, it required review and clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act.[1] Subsequent to this review, OMB approved a four-item questionnaire for the study administered in fiscal year 2005.[2] (See app. III for the approved questionnaire.)

In designing the Survey on Continued Viability of TRICARE Standard (the civilian provider survey), TMA defined the individual states and the District of Columbia as 51 market areas—a definition that will allow TMA to complete the survey of all markets within a 3-year period and to develop estimates of access to health care at both the state and national levels. However, in order to provide information on smaller geographic areas where nonenrolled TRICARE beneficiaries may be having problems finding either network or nonnetwork providers, TMA supplemented the statewide samples by oversampling[3] from submarkets within each state

[1]The Paperwork Reduction Act requires that all federal agency activities that involve collecting information from the public involving 10 or more people be approved by OMB to ensure that collection of this information will have a minimum burden on the public. See 44 U.S.C. §§ 3507 and 3508.

[2]DOD's submission package to OMB included additional questions that OMB did not approve for inclusion in the fiscal year 2005 survey because they did not directly respond to the NDAA for fiscal year 2004. The excluded questions that did not satisfy OMB's clearance criteria included the percentage of a provider's current patient population that uses any form of TRICARE, a provider's willingness to accept new Medicare patients, and if a provider is not accepting new Medicare patients, the reasons why.

[3]The purpose of oversampling is to increase the sample size of some target subpopulation. In this case the target subpopulation is several defined geographic locations within each state that were randomly selected for analysis. Oversampling this subpopulation provides TMA with reliable information about health care providers at the local level to supplement what they learn about providers in each state as a whole.

called Hospital Service Areas (HSA). The HSA geographic designation is derived from a Dartmouth University study that groups zip codes into distinct sets based on the analysis of patient travel patterns to the hospital or hospitals they use most often. TMA endorsed the HSA submarket methodology because these areas are nonoverlapping and encompass all of the United States. In addition, nonenrolled TRICARE beneficiaries reside in almost all of the 3,436 HSAs. TMA's methodology asks for oversamples from HSAs in the 24 states where 80 percent of nonenrolled TRICARE beneficiaries reside. When the study is complete in fiscal year 2007, TMA will have survey data from 2 HSAs selected randomly from each of the 24 states where the majority of nonenrolled TRICARE beneficiaries live, as well as information from HSAs purposively selected because TRICARE beneficiaries or TROs were concerned with access in these areas.

To select the market areas that would be surveyed in fiscal year 2005, TMA randomly selected sites from the individual states and the District of Columbia and randomly selected 12 submarket HSAs within the 20 market areas. In addition, in order to be able to respond to TRICARE beneficiary concerns that access in some locations was impaired, TMA selected 17 additional submarket HSAs that TRICARE beneficiaries had identified as problem areas in terms of access to health care. Four of these 17 sites were outside the 20 selected state-wide market areas because TRICARE beneficiaries had raised concerns about access issues in these locations.

TMA selected its sample for the civilian provider survey from the American Medical Association Masterfile, a data set of U.S. providers that includes data on all providers who have the necessary educational and credentialing requirements. This Masterfile did not differentiate between TRICARE's network and nonnetwork civilian providers. However, TMA selected this file because it is widely recognized as one the best commercially available lists of providers in the United States and contains over 600,000 active providers along with their addresses, phone numbers, and information on practice characteristics, such as their specialty.[4] Although the Masterfile is considered to contain most providers, deficiencies in coverage and inaccuracies in detail remain. Therefore, TMA attempted to update providers' addresses and phone numbers and to ensure that providers were eligible for the survey.

[4]The providers in the American Medical Association's Masterfile are both medical doctors and doctors of osteopathy.

From this Masterfile, TMA expected to randomly sample about 1,000 providers from each market and submarket area—a sample size that would achieve TMA's desired margin of error.[5] However, in some instances, a sample of 1,000 exceeded the number of providers in the market or submarket area, in which case TMA attempted to contact all providers in that area. Overall, TMA initially sampled about 41,000 providers, including both network and nonnetwork civilian providers. After verifying phone numbers and eliminating ineligible providers,[6] TMA attempted to contact about 33,000 office-based providers in the 20 states and 29 HSAs evaluated in fiscal year 2005. When analyzing provider responses, TMA weighted each response so that the sampled providers represented the population from which they were selected.

To administer the civilian provider survey TMA hired a contractor, who conducted the fieldwork for this project. The contractor mailed a combined cover letter and questionnaire to the billing managers for all providers in their sample. If the provider did not respond to the mailed questionnaire, TMA followed up with a second mailing 3 weeks later and conducted a telephone interview within 30 days of the first mailing for those who did not respond to the mailed survey.[7] During the survey period, telephone interviewers called each provider's office up to 10 times in an attempt to obtain a completed survey.

Because the overall response rate to the survey was 55 percent, TMA conducted an analysis of their findings to determine whether the results were biased by a high percentage of providers not responding. Although TMA officials told us that OMB's approval for the fiscal year 2005 survey did not specify a required response rate, OMB's public guidance specifies that if response rates are lower than 80 percent, agencies need to conduct a nonresponse analysis.[8] Such an analysis is used to verify that

[5]TMA ultimately dropped the sample size for each market and submarket area to about 800 providers in each location in order to accommodate both randomly and judgmentally selected sites and remain within its resourced and OMB-approved overall sample of about 40,000 physicians. According to TMA officials, the reduction in sample size did not affect the sample outcomes and their ability to project results.

[6]According to TMA officials, providers were ineligible for such reasons as being employed by the military or the government.

[7]The questionnaire or phone interview was directed to an administrative staff person in the provider's office.

[8]According to OMB officials, this is a common industry practice when there is potential for concern about the reliability of survey results due to a low response rate.

nonrespondents to the survey would not answer differently from those who did respond and that the respondents are representative of the target population, thus ensuring that the data are statistically valid. When conducting this analysis, TMA interviewed a sample of providers who did not respond to the original survey and compared their responses and demographics with the original survey respondents.[9] TMA also compared nonrespondents' demographics with those of the target population of health care providers. The results of TMA's nonresponse analysis indicate that the survey respondents are representative of the target population of providers.

The nonresponse analysis provided additional useful information for TMA. First, it did not show a difference in the rate that responding and nonresponding network civilian providers were aware of the TRICARE program. However, it did show a statistically significant difference in the rate of awareness between responding and nonresponding nonnetwork civilian providers. These results indicate that having a familiarity with TRICARE increases a provider's incentive to respond to the survey. In order to adjust for this bias, TMA could have calculated an adjustment to the sampling weights—an adjustment that has not been applied to the survey results. As a result, the unweighted survey results tend to overstate civilian providers' awareness and acceptance of TRICARE.[10] Nonetheless, TMA's survey contractor noted that the survey results are not problematic if the survey is used to compare changes in awareness and acceptance from year to year. Further, TMA's use of the unadjusted results of the initial survey phase as indicators of areas in which to focus marketing and outreach efforts is appropriate because TMA is using it to make relative comparisons of the areas surveyed.

TMA's survey of civilian providers continues, and their analysts expect to complete data collection for the nation over a 3-year period ending in fiscal year 2007. Although TMA's efforts meet the mandate's requirement of surveying 20 market areas each fiscal year until all market areas were surveyed, collecting survey results over this period may limit TMA's stated goal of deriving an overall national estimate because the national estimate will combine data collected over several years rather than during one

[9]For example, TMA compared provider specialty and network status between the original respondents and the nonrespondents in bias analysis.

[10]According to TMA officials, TMA expects to provide post-survey weighting to account for differential response rates.

relatively short time period, as well as the likelihood different instruments will be used over time. For example, four additional questions may be added to the fiscal year 2006 survey. TMA officials told us that the time lag could potentially impact the results used to derive a national estimate, but that their limited resources for this study prevent them from conducting a nationwide survey under a shorter time frame.

Appendix III: Civilian Provider Survey Instrument

The National Defense Authorization Act (NDAA) for fiscal year 2004 directed the Department of Defense (DOD) to monitor nonenrolled TRICARE beneficiaries' access to care under the TRICARE Standard option.[1] Although the mandate focused on Standard, nonenrolled TRICARE beneficiaries can receive care from both nonnetwork civilian providers through the Standard option and from network civilian providers through the Extra option. Beneficiaries can move freely between these options depending on their choice of civilian provider each time they receive care. Therefore, DOD's survey was designed to monitor nonenrolled beneficiaries' access to care from both network and nonnetwork providers. As each cycle of the survey is completed, TMA will be able to project survey results to the sampled market areas. When all cycles of the survey are complete, TMA will be able to project the survey data at the national level.

Following is the actual survey instrument that was used to obtain information from civilian providers. The staff administering this survey were not aware of whether the civilian providers they contacted were network or nonnetwork, and the same survey questions, which specifically mentioned the Standard option, were asked of all respondents. Nonetheless, if network civilian providers were to deliver care to nonenrolled beneficiaries, the responding providers' staff would likely understand that this care would be provided under the Extra option. Therefore, for the purposes of the survey, the term "Standard" referred to both the Standard and Extra option.

[1]See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003) and S. Rep. No. 108-46, at 330 (2003).

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

TRICARE MANAGEMENT ACTIVITY
HEALTH PROGRAM ANALYSIS AND EVALUATION DIRECTORATE

[Unique Physician ID Number]

ATTN: BILLING MANAGER
FOR [Insert Physician Name]
Street Address
City, State, and Zip

Dear Billing Manager,

Hello! In support of the thousands of U.S. military men and women who are currently defending our communities at home and abroad, Congress is interested in whether family members of active duty military, and military retirees and their families, have sufficient access to the health care they need. Much of their care is delivered at military facilities; however, a substantial amount of health care is delivered by private, civilian physicians. The Department of Defense (DoD) health care benefits program is known as TRICARE, and we need your help in answering the enclosed survey.

To determine the adequacy of private health care access, Congress has directed DoD's TRICARE program to survey civilian providers across the U.S. The TRICARE program has contracted Synovate to conduct this survey. The physician named above was randomly selected to participate in this very important effort.

Please answer the questions on the back of this letter and return it in the provided postage paid envelope or fax the completed survey to 1-800-585-9446 within five days of receipt. Please note that more than one survey may have been sent to you. If you are responsible for more than one physician, please complete each survey only for the physician listed above. If you are not the appropriate person to answer these questions, please pass this on to the person in your office who would be able to.

Thank you in advance for your cooperation and help as we examine this important issue that impacts our American service men and women. If you have questions about this survey, please call Synovate between the hours of 8 AM and 5 PM Eastern Time at 1-800-228-6764.

Thank you again.

Sincerely yours,

Michael R. Peterson

Michael R. Peterson, DVM, MPH, DrPH
Director
Office of the Assistant Secretary of Defense (Health Affairs)
TRICARE Management Activity/Health Program Analysis and EvaluatioreDirectorat

SURVEY QUESTIONS ON REVERSE SIDE

[Unique Physician ID Number]
[Bar Code]

OMB NO.: 0720-0031
EXPIRATION DATE: 05/31/2008

Are you the person in the office who is most familiar with billing and insurance for Dr. X? If so, please answer the following questions. If not, please give this to the person who is the most familiar with billing and insurance for Dr. X.

Q1. Is Dr. X aware of the TRICARE health care program?

- ☐ Yes
- ☐ No
- ☐ Don't Know

Q2. As of today, is Dr. X accepting NEW TRICARE Standard patients?

- ☐ Yes, for all claims ..... (Go to Q4)
- ☐ Yes, on a claim-by-claim basis only ..... (Go to Q4)
- ☐ No ..... **(Go to Q3)**
- ☐ Don't know ..... (Go to Q4)

Q3. What are the reasons Dr. X is not accepting new TRICARE Standard patients? Please list all the reasons. (IF ADDITIONAL SPACE IS NEEDED, PLEASE INCLUDE A SEPARATE SHEET OF PAPER.)

_____
_____
_____
_____
_____

Q4. As of today, is Dr. X accepting ANY new patients?

- ☐ Yes
- ☐ No
- ☐ Don't Know

Thank you for taking the time to complete this survey.

Please put this in the enclosed postage-paid envelope and return it to the Survey Processing Center or fax the survey to Synovate at 1-800-585-9446

If you have any questions about TRICARE, its specific health plans, or the benefits it provides, please visit the TRICARE web site at www.tricare.osd.mil for assistance.

Appendix IV: Categorized Responses to the Civilian Provider Survey's Open-ended Question

Table 7: "What are the reasons Doctor X is Not Accepting New TRICARE [Nonenrolled] Patients?"

	Percent of providers who cited this reason		
Reason for not accepting new TRICARE patients	**Network (Extra) providers**	**Nonnetwork (Standard) providers**	**All providers**
Doctor not available	31	29	29
Reimbursement	20	25	24
Other/miscellaneous	12	11	12
Administrative inconveniences	15	7	8
Takes other forms of TRICARE	7	8	8
Specialty not covered	6	6	6
Insurance/image problems	3	6	5
Not aware of TRICARE	1	3	3
Only takes certain insurance	0	3	3
Customer service	4	2	2
Application in process	0	1	1
Total percent	**99**[a]	**101**[a]	**101**[a]
Total responses	**378**	**3837**	**4215**

Source: GAO analysis of DOD data.

[a]Total does not equal 100 percent due to rounding errors.

Appendix V: TRICARE Reimbursement Rates That Remain Higher than Medicare Reimbursement Rates

CPT code[a]	Procedure or service performed	Ratio of TRICARE to Medicare reimbursement
20250	Biopsy, vertebral body, open; thoracic	1.007
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic	2.980
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous	2.954
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	1.090
58600	Litigation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	1.084
58605	Litigation or transaction of fallopian tube(s), abdominal or vaginal approach, postpartum, unlaterial or bilateral, during same hospitalization (separate procedure)	1.024
58615	Occlusion of fallopian tube(s) by device (eg. Band, clip, Galope ring) vaginal or suprapubic approach	1.040
59012	Cordocentesis (intrauterine), any method	1.137
59020	Fetal contraction stress test	1.427
59025	Fetal non-stress test	1.184
59030	Fetal scalp blood sampling	1.210
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	1.324
59051	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; interpretation only	1.219
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	1.016
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	1.017
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	1.161
59320	Cerciage of cervix, during pregnancy; vaginal	1.122
59325	Cerciage of cervix, during pregnancy; abdominal	1.094
59350	Hysterorrhaphy of ruptured uterus	1.205
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	1.184
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum car	1.156
59412	External cephalic version, with or without tocolysis	1.139
59414	Delivery of placenta (separate procedure)	1.190
59514	Cesarean delivery only	1.175
59515	Cesarean delivery only; including postpartum care	1.126
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	1.118
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	1.104

CPT code[a]	Procedure or service performed	Ratio of TRICARE to Medicare reimbursement
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1.127
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	1.078
59812	Treatment of incomplete abortion, any trimester, completed surgically	1.044
59840	Induced abortion, by dilation and curettage	1.217
59850	Induced abortion, by one or more intra-amniotic injuctions (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines	1.021
59851	Induced abortion, by one or more intra-amniotic injuctions (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	1.019
59855	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secudines	1.015
59856	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secudines; with dilation and curettage and/or evacuation	1.046
59857	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secudines; with hysterotomy (failed medical evacuation)	1.058
59866	Multifetal pregnancy reduction(s) (MPR)	1.151
63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equine or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)	1.003
67334	Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)	1.025
92953	Temporary transcutaneous pacing	2.965
93541	Injection procedure during cardiac catheterization; for pulmonary angiography	1.624
93542	Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography (eg.internal mammary), whether native or used for bypass.	1.216
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	1.558
93544	Injection procedure during cardiac catheterization; for aortography	1.979
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	1.833
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	1.198
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	1.320
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	1.901

Source: GAO analysis of DOD data.

[a]Current Procedural Terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers.

Appendix VI: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

NOV 14 2006

Ms. Marcia Crosse
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Crosse:

This is the Department of Defense (DoD) response to the GAO draft report, GAO-07-48, "DEFENSE HEALTH CARE: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option," dated October 16, 2006 (GAO Code 290398).

Thank you for the opportunity to review and comment on the draft report. First, let me say that I appreciate the collaborative, insightful, and thorough approach your team has taken with this important issue.

Technical comments about the draft report are enclosed. There is one discrepancy, however, that I am compelled to specifically address because it indicates GAO misunderstands a fundamental delegation of responsibility and accountability for management of the health program. Several instances within the draft report state that DoD has not formally designated a senior official with responsibility for non-enrolled TRICARE beneficiaries and non-network civilian providers as outlined in the National Defense Authorization Act for Fiscal Year 2004 (NDAA for FY04). This is incorrect. By directive (DoDD 5136.12), the Secretary of Defense has formally designated the TMA Director to "serve as the program manager for TRICARE health and medical resources, supervising and administering TRICARE programs, funding, and other resources within the DoD." The Directive further assigns to the TRICARE Regional Offices the responsibility and accountability for "ensuring the consistent implementation and management of MHS policies and the uniform health benefit within their geographical area" and "development and execution of an integrated plan for the delivery of health care within the geographic region." The scope of this responsibility clearly encompasses provision of care to non-enrolled beneficiaries, whether by network or non-network civilian providers. Congress has recognized the appropriateness of this assignment by requiring, in the NDAA for FY06, an annual report of the TRICARE Regional Office's efforts to monitor, oversee, and improve TRICARE Standard.

Again, thank you for the opportunity to provide these comments. My points of contact for additional information are Mr. Michael O'Bar (functional) at (703) 681-0039 and Mr. Gunther Zimmerman (audit liaison) at (703) 681-3492.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

Appendix VII: GAO Contacts and Staff Acknowledgments

GAO Contact

Marcia Crosse (202) 512-7119 or crossem@gao.gov

Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director, Kevin Dietz, Cathleen Hamann, Lois Shoemaker, Robert Suls, and Suzanne Worth made key contributions to this report.

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